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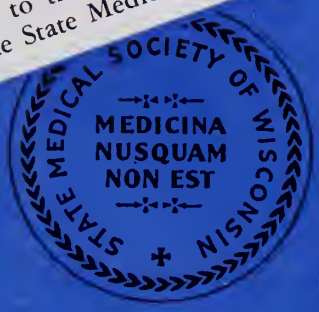
ANNUAL "BLUE BOOK" ISSUE

PRESENTED EACH YEAR SINCE 1924

Articles relative to medicolegal, socio-economic matters of direct concern to the physician in relationship to governmental agencies . . . membership roster, services and structure of the State Medical Society of Wisconsin



official publication of
THE STATE MEDICAL SOCIETY OF WISCONSIN

JANUARY 1965

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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the wisconsin medical journal

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PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

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Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Index Medicus* published monthly by the National Library of Medicine, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

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Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

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*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Responded to Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

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Brief Summary and Bibliography follow.

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OBITUARIES

Dr. Joseph Howard Young, a general practitioner in Elkhorn for 50 years, died May 27, 1964, at the age of 75.

Doctor Young, who received his medical degree from Northwestern University Medical School, Evanston, Ill., and served his internship in Salt Lake City, Utah, is survived by two sons, Prof. George H., Madison, and Frederick, Elkhorn. He was the third generation of his family to serve in the medical profession in Elkhorn.

Doctor Young was a former member of the Walworth County Medical Society and the State Medical Society of Wisconsin.

Dr. Leo W. Egloff, Pewaukee physician and surgeon for 50 years, died July 16, 1964. He was 78 years old.

Born in Fort Atkinson, Doctor Egloff was a 1910 graduate of Marquette University School of Medicine. He practiced in Elkhart Lake for four years before moving to Pewaukee. He was a former member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Besides his regular practice, he served as town and village health officer.

Among his survivors are his widow, Luella; one son, Robert F., San Antonio, Tex., and one daughter, Mrs. Bettie Lou Koeppel, Pewaukee.

Dr. Louis J. Bennett, 88, who practiced at Wisconsin Rapids from 1935 until his retirement early in 1949, died July 21, 1964, in Lawrenceville, Ill.

An eye, ear, nose, and throat specialist, Doctor Bennett had practiced at Fort Atkinson before locating in Wisconsin Rapids. He was a former member of the Wood County Medical Society and the State Medical Society of Wisconsin.

Surviving are a daughter and son, Mrs. Charles Stoll, Lawrenceville, Ill., and Dr. William H. Bennett, Racine.

Dr. Dorothy Reed Mendenhall, 89, famed retired pediatrician and founder, in 1915, of the Madison Child Health Centers in connection with the Visiting Nurse System, died July 31, 1964, in Chester, Conn., where she had resided since 1958.

A native of Columbus, Ohio, who graduated from Johns Hopkins Medical School in 1900 in the fourth class, Doctor Mendenhall interned under Dr. William Osler at Johns Hopkins in 1901, and the next year was named fellow in pathology. After her marriage in 1906 to Prof. Charles Elwood Mendenhall, she maintained her legal residence in Madison.

Among her survivors are two sons, Dr. Thomas Corwin Mendenhall II, president of Smith College, Northampton, Mass., and Dr. John Talcott Mendenhall, professor of surgery at the University of Wisconsin Medical School, Madison.

Dr. Theodore H. Joyner, 61, Hendersonville, N.C., died August 2, 1964, at Ellsworth, Kan.

A native of Bruce and graduate of Loma Linda Medical College, Loma Linda, Calif., Doctor Joyner interned at Madison General Hospital, Madison, and practiced at Mt. Horeb and Oregon until about 20 years ago when he moved to Hendersonville. There are no immediate survivors.

Dr. Frank H. Kennedy, Waterloo physician since 1931, died August 29, 1964, at the age of 84. He had practiced in Owen, Greenwood, Withee, Iron Ridge, and Beaver Dam before locating in Waterloo.

Born in Shelbina, Mo., Doctor Kennedy was a 1910 graduate of the Chicago College of Medicine and Surgery. During the first World War, he served as an officer in the Army Medical Corps. He was a member of the Jefferson County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Surviving is Doctor Kennedy's widow, Emily.

Dr. Arnold S. Jackson, 71, internationally renowned surgeon and former director of the Jackson Clinic, Madison, died August 30, 1964.

He was known throughout the world for his medical writings and throughout Wisconsin for his far-ranging interests in travel, flowers and shrubbery, sports, photography, seashells, and writing.

Doctor Jackson was the son of the late Dr. James A. Jackson, Sr., who founded the Jackson Clinic in 1917, and the grandson of Dr. Joseph Hobbins, both pioneer Madison doctors. Clinic co-founders were three of his brothers, Drs. Reginald, James, Jr., and J. W. Jackson. Four of Doctor Jackson's nephews are also physicians.

Following his graduation in 1919 from the College of Physicians and Surgeons at Columbia University, New York, Doctor Jackson interned at Madison General Hospital, Madison, and St. Luke's Hospital, New York City. His residency was served at the Mayo Clinic, Rochester, Minn., where he was assistant to Dr. Charles Mayo. He joined the Jackson Clinic in 1922, and was its director from 1951 until his retirement from that post in May 1963. He was chief of staff of the Methodist Hospital, Madison, and voluntary medical consultant at St. Coletta's School, Jefferson.

An authority on the subject of goiter, he had been president of the American Association for the Study of Goiter, and president, also, of the United States chapter of the International College of Surgeons and the Wisconsin Surgical Society. He was a founding member of the American Board of Surgery and a member of the Western Surgical Association, American College of Surgeons, Wisconsin Surgical Travel Club, and the American Association of Railway Surgeons. Surgical societies in Rome, Madrid, Florence, St. Paul, Minn., Sao Paulo, Brazil, the University of Bordeaux Medical School, and the University of Vienna granted him honorary memberships, and he

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Note:
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*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded to Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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was also a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

A prolific writer, on his travels as well as on medical subjects, he held a fellowship in the American Medical Writers' Association, was a member of the American Medical Authors, and won a Book of the Month Club recommendation for his book, "The Answer Is—Your Nerves." He was a member of the Mayo Alumni Foundation; and numerous other organizations, in Madison and elsewhere, also claimed him as a member.

Survivors include his widow, Lora; a son, Arnold, Jr., Morrisonville; and a daughter, Mrs. William Russell, Westport, Conn.

Dr. Joseph P. Healy, 42, New Richmond, died August 31, 1964.

Born in Omaha, Neb., he received his medical degree in 1945 from Creighton University in Omaha. He interned at St. Joseph's Hospital, St. Paul, Minn., and after two years of army service, he served his residency at St. Luke's Hospital in St. Paul.

Doctor Healy had practiced in New Richmond intermittently for about 15 years, and was on the staff of Holy Family Hospital there. He was a member of the Pierce–St. Croix County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Ann, and four children.

Dr. Milton Feig, 58, director of the section on preventable diseases of the Wisconsin State Board of Health, died September 20, 1964, in Madison.

Doctor Feig was born in New York City, where he obtained his medical degree from New York University, and his master of public health degree from Columbia University. He came to Wisconsin in 1949.

Doctor Feig was a past president of the Middle States Public Health Association and a consultant to the Division of Research Grants in Accident Prevention of the National Institutes of Health. He was a frequent contributor to the *Wisconsin Medical Journal, American Journal of Public Health,* and *Public Health Reports.*

Among his survivors are his widow, Rosanne; a daughter, Barbara, at home; and a brother, Dr. Ralph Feig, New York City. Another daughter, Mrs. Perry Silveira, also survived her father but died November 1 following an auto accident near Berkeley, Calif., where she was studying for a master's degree in social work at the University of California.

Dr. Jeffrey J. Brook, Wauwatosa, died October 8, 1964, at the age of 81.

A native of Hokah, Minn., Doctor Brook was a 1913 graduate of the Medico Chirurgical College in Philadelphia, Pa., and interned at Milwaukee County Hospital. He was engaged in general practice in Milwaukee from 1914 to 1917, when he became an eye, ear, nose, and throat specialist.

He was a member of the Milwaukee Oto-Ophthalmic Society until his retirement January 1, 1949. He was also a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. During World War I he served with the Medical Corps in Europe.

Survivors include two sons, Dr. Jeffrey J., Jr., Sturgeon Bay, and Roger F., Pewaukee.

Dr. Albert J. Randall, former director of the Kenosha City Health Department, died October 8, 1964, at the age of 77.

Born in Seeleys Bay, Ontario, Canada, he received his degree as doctor of medicine in 1911 from Queen's University, Kingston, Ontario, and interned at Smith Hospital, South Milwaukee. After engaging in general practice at Kenosha from 1911 until 1917, he served as a captain in the Canadian Army Medical Corps from July of 1917 until September of 1919, when he resumed his practice in Kenosha. On November 12, 1935, he was appointed director of health for the city of Kenosha, a position he filled until his resignation in November 1951.

Doctor Randall was a past director of the Visiting Nurse Association, past president and operational director for the Kenosha Tuberculosis Association, a member of the American Public Health Association, the Kenosha County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Among his survivors are his widow, Lillian, and a daughter, Mrs. Paul Taft, Kenosha.

Dr. Max E. Wiese, Milwaukee pediatrician, died October 10, 1964, at the age of 67.

A native of Milwaukee, he received his M.D. degree in 1927 from the University of Illinois Medical School at Chicago and served his internship at Iowa Methodist Hospital in Des Moines, Iowa.

After many years of private practice, Doctor Wiese closed his office and served in a fulltime capacity with the Milwaukee Health Department.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Lorraine, and a brother, Herbert C. Wiese, Richmond, Calif.

Dr. Charles A. Merulla, 40, a resident doctor in anesthesiology at the Veterans Administration Hospital at Wood since August 1, died October 12, 1964, in Milwaukee.

A native of Syracuse, N.Y., Doctor Merulla practiced in Marion, Iowa, for six years before moving to Wisconsin. Among his survivors are his widow, Edithmerle, and three sons, Anthony, Michael, and James.

Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Responded to Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

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OBITUARIES *continued*

Dr. George H. Chesky, Brookfield, died October 15, 1964, at the age of 69.

A graduate of Marquette University School of Medicine, he interned at St. Mary's Hospital, Milwaukee. His widow, Florence, survives.

Dr. Howard J. Barry, a native of the town of Fitchburg who practiced in Sun Prairie in the early 1900's and retired to that community in 1949, died November 10, 1964, in Watertown at the age of 85.

Doctor Barry was a U.S. Veterans Administration physician in Washington, D.C., from 1925 to 1949. He was a veteran of World War I.

His widow, Mary, survives.

Dr. Julius Blom, a native of Norway who came to the United States in 1917, died November 28, 1964, at the age of 73. He had been associated with the Midelfart Clinic in Eau Claire since 1943. Prior to his association there he had practiced in Menomonie and Woodville.

Surviving Doctor Blom are his widow, Celia, and two sons, Gustav Peter, Geneva, Ill., and John Olaf, with the U.S. Army in Germany.

Dr. E. J. Mittermeyer, longtime Cornell physician, died December 16, 1964, at the age of 64.

A native of Boyd, Doctor Mittermeyer saw active duty with the U.S. Navy in 1917–1918 before enrolling at the University of Wisconsin, where he received his M.D. in 1931. He interned at Luther Hospital, Eau Claire, before establishing a practice in Cornell in 1933. For the 10 years preceding his death he had been on the staff of the Northern Wisconsin Colony and Training School, Chippewa Falls.

Survivors include his widow, Adeline; two sons, Frank, La Crosse, and Joseph, at home; and eight daughters, Mrs. Rune Ruud, Mrs. Kenneth Blanchard and Mrs. Daniel Boharty, all of Cornell; Jane, Lee, and Gail, Madison; Betty, Eau Claire, and Peggy, at home.

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HOTEL SCHROEDER, MILWAUKEE . . . MAY 4–6, 1965

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin.

NUMBER OF ENTRIES: There is no limit to the number of entries allowed to any exhibitor.

DEADLINE FOR ENTRIES: All entries must be at the State Medical Society headquarters in Madison on or by April 1, 1965.

NOTIFICATION OF INTENT TO EXHIBIT: It will be appreciated if all interested physicians would submit an entry form as early as possible so that proper arrangements can be made prior to judging and exhibiting. (See Below)

REQUIREMENTS: (1) All entries must be mounted on white mounting boards 16x20 inches only. Boards will be exhibited in vertical position only; (2) Prints may be of any size up to 16 x 20 inches if verticals, 11 x 14 if horizontals; (3) Prints must be placed singly on mounting boards; (4) Entries must carry the following information on the back of the mounting: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or on any photo; (5) All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

CLASSIFICATIONS FOR ENTRIES: Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape—things—still life, etc.).

AWARDS: Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

ANNOUNCEMENT OF AWARDS: Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

ENTRY FORM

Mail to State Medical Society of Wisconsin, P. O. Box 1109, Madison BEFORE YOU SUBMIT YOUR ENTRY. All entries must be submitted before April 1, 1965.

Name of Exhibitor: _____

Address: _____

Please indicate total entries

Black and White	Color
Classification: _____	Classification: _____
_____	_____
_____	_____
_____	_____
_____	_____

1965 **Wisconsin**

Feb. 17: U. W. "In Depth" program—Orthopedics: "Congenital Hips and Foot Deformities in Children" —at University Hospitals and State Medical Society, Madison.

Mar 3, 10, 17, 24: Marquette University School of Medicine and Milwaukee Children's Hospital, postgraduate course in pediatrics, 7–9:30 p.m., Amphitheater of Milwaukee Children's Hospital, 1700 W. Wisconsin Ave., Milwaukee. Send reservations to: Joseph W Rastetter, M.D., Director Postgraduate Medical Education Programs, Marquette University School of Medicine, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

Mar. 17–18: Wisconsin Hospital Association, Schroeder Hotel, Milwaukee.

Mar. 18: U. W. "In Depth" program—Obstetrics and Gynecology: "Endocrine Problems in Gynecology"—at University Hospitals and State Medical Society, Madison.

Mar. 19: Small Hospital Seminar, Schroeder Hotel, Milwaukee.

Mar. 27–28: Wisconsin Psychiatric Association, Milwaukee chapter, two-day course for general practitioners, Coach House, Milwaukee, cosponsored by Wisconsin Academy of General Practice, Department of Psychiatry at Marquette University School of Medicine, and Milwaukee Sanitarium Foundation

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 1–3: University of Wisconsin Department of Pediatrics, annual postgraduate seminar, "Importance of Immune Mechanisms in Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

Apr. 5–8: National Association of Recreational Therapists, annual institute, Wisconsin Center, University of Wisconsin, Madison.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

Feb. 4–Apr. 22: Cardiovascular Section, Hahnemann Medical College and Hospital, postgraduate course in clinical electrocardiographic interpretation, every Thursday, 230 N. Broad St , Philadelphia, Pa. 19102.

Feb. 20–23: University of Utah College of Medicine, annual postgraduate course in anesthesiology, Salt Lake City.

Feb. 22–26: American College of Physicians, postgraduate course No. 8, pain and addiction, Massachusetts General Hospital, Boston, Mass.

Mar. 1–4: Chicago Medical Society, annual clinical conference, Palmer House, Chicago.

Mar. 1–5: American College of Physicians, postgraduate course No. 9, molecular biology and clinical medicine, Philadelphia General Hospital, Philadelphia, Pa

Mar. 3–5: University of Colorado School of Medicine, postgraduate course on management of trauma, Denver.

Mar. 7: American College of Gastroenterology, southern regional meeting, Roosevelt Hotel, New Orleans, La.

Mar. 8–11: New Orleans Graduate Medical Assembly, 28th annual meeting, Roosevelt Hotel, New Orleans, La

Mar. 8–12: American College of Physicians, postgraduate course No. 10, recent advances in cardiovascular disease, Mount Sinai Hospital, New York, N.Y.

Mar. 13–18: International Academy of Proctology, 17th annual teaching seminar, Jung Hotel, New Orleans, La.

Mar. 15–19: American College of Physicians, postgraduate course No 11, cardiology, Emory University School of Medicine, Atlanta, Ga.

Mar. 15–19: University of Colorado School of Medicine, postgraduate course on medical technology, Denver.

MEDICAL MEETINGS

POSTGRADUATE COURSES

March 15–20: University of Colorado School of Medicine, 6th postgraduate course in medical technology.

Mar. 22–26: American College of Physicians golden anniversary session, Conrad Hilton Hotel, Chicago, Ill.

Mar 24: Wayne State University, 7th annual "Resident's Day" in obstetrics and gynecology, Wayne County Medical Society Building, 1010 Antietam St. at Rivard, Detroit, Mich.

Mar. 28–Apr. 1: International Anesthesia Research Society, 39th congress, Washington, D. C.

Mar. 29–Apr. 10: Postgraduate course in laryngology and bronchoesophagology given by Department of Otolaryngology, College of Medicine of University of Illinois, at Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill.

Mar. 31–Apr. 2: Medical education symposium on gastroenterology, Medical College of Georgia, Augusta, Ga.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 5–8: American industrial health conference, sponsored by Industrial Medical Association and American Association of Industrial Nurses, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

Apr 21–24: Methodist Hospital Graduate Medical Center Department of Otolaryngology, in cooperation with American Rhinologic Society, introductory course in expanded surgery of nasal septum at medical center, Indianapolis, Ind.

Apr. 26–29: American Academy of Pediatrics, spring session, Americana Hotel, Bal Harbour, Miami Beach, Fla.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30–Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

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Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record – confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low.

1. Kunin, C. M. et al.: J. Clin. Invest. 38:1950, Nov., 1959.

WPA Course for General Practitioners

Through its Milwaukee chapter, the Wisconsin Psychiatric Association has made plans for a two-day course for general practitioners, to be held March 27 and 28 at the Coach House, Milwaukee.

Cosponsoring the course, which will carry credit, are the Wisconsin Academy of General Practice, the Department of Psychiatry at Marquette University School of Medicine, and the Milwaukee Sanitarium Foundation. The fee is $25.

Appointed by Dr. Jack J. Coheen, current president of Milwaukee Chapter of the WPA, Dr. H. Gladys Spear, Milwaukee, is chairman of the committee which planned the course. General topic will be "Emotional Problems of Adolescents," with participation in general limited to WPA members trained in child psychiatry.

WSIM Plans Joint Meeting with ACP

The Council of the Wisconsin Society of Internal Medicine has approved a recommendation to hold the 1965 annual meeting jointly with the 1965 regional meeting of the American College of Physicians. Dr. J. LeRoy Sims, Madison, WSIM past president, is ACP governor for Wisconsin and in charge of arrangements for the regional meeting. The joint session is scheduled for October 15 and 16 at the Wisconsin Center, Madison.

Orthopedic Program at UW Feb. 17

The fourth "In Depth" teaching program of the University of Wisconsin Medical School, on "Congenital Hips and Foot Deformities," will be held Wednesday, February 17. Those interested should register by writing Roy T. Ragatz, State Medical Society of Wisconsin, Box 1109, Madison. Registration fee, including lunch and special parking at University Hospitals for the morning program, is $5.00. Checks are to be made payable to CES Foundation.

Dr. Charles Heck, Chicago, will be the guest lecturer on the all-day program. In the morning, starting at 10 o'clock, cases will be presented to indicate congenital dislocation of the hip, Perthe's Disease and coxa vara, among others. Following lunch at the State Medical Society headquarters, discussions will be directed to the subject of hip deformities, with Drs. Peter Golden, Jack Heiden, Kenneth McDonough, H. I. Okagaki, S. C. Rogers, and H. W. Wirka as participants. Doctor Heck will present a lecture on foot problems in infancy and childhood.

The program will provide educational credit for all AAGP members in attendance, as it was planned cooperatively with the Madison chapter of the Wisconsin Academy of General Practice. The program is open to all licensed MD's.

The final program in the series: "Endocrine Problems in Gynecology," with Dr. Hilton Salhanick, Boston, as guest faculty member, will be presented Thursday, March 18. Physicians interested in attendance should register by writing Mr. Ragatz at the State Medical Society office (Box 1109, Madison, Wis.).

ACP Golden Anniversary

The golden anniversary session of the American College of Physicians will be held in Chicago March 22–26 at the Conrad Hilton Hotel.

Meeting highlights will be presentations by prominent internists who received top awards from ACP in 1933, 1949, and 1957, and an emphasis on the relationship of psychiatry to internal medicine. Some 300 physicians and other medical scientists, including two from Norway and Switzerland, will take part.

For information, write Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia, Pa. 19104.

ACG Southern Regional Meeting

The southern regional meeting of the American College of Gastroenterology is scheduled for Sunday, March 7, at the Roosevelt Hotel in New Orleans, La. It will precede by one day the New Orleans Graduate Medical Assembly.

Members of the medical profession are invited to attend. A copy of the program may be obtained from the Secretary, American College of Gastroenterology, 33 West 60th Street, New York, N.Y. 10023.

Three ACP Courses Slated in March

Three postgraduate courses are scheduled for the month of March by the American College of Physicians.

"Molecular Biology and Clinical Medicine" is the title of Course No. 9, which will be held March 1–5, 1965, at Philadelphia General Hospital, Philadelphia, Pa. Recent advances in molecular biology will be related to the pathogenesis, diagnosis and treatment of a number of diseases with which the internist is faced. Lectures, patient presentations and clinical demonstrations will be used to illustrate the subject material.

Course No. 10, "Recent Advances in Cardiovascular Disease," will be presented March 8–12 at Mount Sinai Hospital, New York, N.Y.

Emory University School of Medicine, Atlanta, Ga., will be the setting for Course No. 11, "Cardiology," March 15–19. The course will be divided into 10 units of approximately four hours each, designated as follows: Modern Physical Diagnosis of the Cardiovascular System, three units; Coronary Disease, two units; Modern Management of Cardiac Arrhythmias, Hypertension, Rheumatic Heart Disease, Congenital Heart Disease, one unit each.

Tuition fees are $60 for members and $100 for nonmembers. Registration forms and requests for information for the courses may be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Wisconsin Postgraduate Pediatric Seminar

"The Importance of Immune Mechanisms in Clinical Pediatrics" will be the subject of the annual postgraduate seminar of the University of Wisconsin Department of Pediatrics April 1–3, 1965, in the Wisconsin Center building at the University of Wisconsin, Madison.

The faculty will include Dr. Clark West, professor of pediatrics, University of Cincinnati; Dr. Ralph Wedgewood, professor and chairman, Department of Pediatrics, University of Washington; Dr. Richard Smith, professor and chairman, Department of Pediatrics, University of Florida; and Dr. E. Richard Stiehm, fellow in pediatrics, University of California. Members of the Wisconsin faculty participating include Dr. Oliver Smithies, professor of medical genetics; Dr. Robert Auerbach, professor of zoology, and members of the Department of Pediatrics.

The seminar will provide basic information on the nature and genesis of immune mechanisms, their importance in the production of disease and use in its prevention. Teaching will include lectures, panel discussions, and small discussion groups.

The seminar is open to all physicians. Registration fee is $50. Address inquiries to: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison, Wis. 53706.

ACOG Annual Meeting April 4–8

The American College of Obstetricians and Gynecologists will hold its 13th annual clinical meeting April 4–8, 1965, at the Civic Auditorium, San Francisco. Registration is open to all physicians.

Among the topics scheduled for discussion treatment are the role of the OBG physician in marriage and family problems, amenorrhea, early fetal loss, cervical cancer, reproductive biology, dysfunctional bleeding, perinatal loss, sociologic and medical aspects of sterilization, toxemia, and bleeding in late pregnancy.

Topics of formal papers will include prenatal factors influencing the premature infant, treatment of vulvar malignancies, surgical treatment of cervical cancer, elective induction of labor, fetal salvage in eclampsia, pregnancy and progeny after prolonged use of progestin-like substances for contraception, and the effects of caudal anesthesia on uterine activity.

Registration fee is $25. Interested physicians may write: The American College of Obstetricians and Gynecologists, 79 W. Monroe St., Chicago, Ill. 60603, for a preliminary program and housing and registration forms.

Illinois Postgraduate Course

The Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from

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MEDICAL MEETINGS *continued*

March 29 through April 10, 1965. Limited to 15 physicians, the course will be under the direction of Dr. Paul H. Holinger and will be held at the new Illinois Eye and Ear Infirmary, 1855 W. Taylor Street, Chicago. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants may write directly to: Dept. of Otolaryngology, College of Medicine of University of Illinois at Medical Center, 1853 W. Polk St., Chicago, Ill. 60612.

American Academy of Pediatrics

The American Academy of Pediatrics will hold its spring session April 26–29 at the Americana Hotel, Bal Harbour, Miami Beach, Fla. Numbering some 8500 members in the United States, Canada, and Latin America, the Academy is the Pan-American association of pediatricians.

Following the meeting, the Puerto Rico Chapter of the Academy will present a special clinical program in San Juan on May 1. A tour of the Caribbean is being arranged in conjunction with the San Juan meeting for interested Academy members.

Registration fees are $15 for Academy members, applicants to the Academy or the American Board of Pediatrics, nonmembers out of school less than

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five years, and physicians in the Armed Forces, and $25 for nonmember physicians. Those interested may write: American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204, for a preliminary program and housing and registration forms.

Medical Education Symposium

A continuing medical education symposium on gastroenterology will be presented March 31–April 2 at the Medical College of Georgia, Augusta, Ga. The guest faculty includes three nationally recognized teachers and clinicians who will join with members of the college faculty in discussing the medical and surgical approach to problems in gastroenterology.

Sports-minded physicians are reminded that the symposium immediately precedes the Masters Golf Tournament April 4–11 at the Augusta National Golf Club.

For a brochure listing the subjects to be discussed and the participating faculty, write to the Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

Course in Nasal Surgery

An introductory course in "Expanded Surgery of the Nasal Septum" will be presented at the Methodist Hospital Graduate Medical Center, Indianapolis, Ind., April 21–24, under the sponsorship of the Department of Otolaryngology with the cooperation of the American Rhinologic Society. The instructional staff will include two Wisconsin physicians, Drs. Charles J. Finn and Irwin E. Gaynon, Milwaukee.

A preliminary program or other information may be obtained from the Educational Committee of the American Rhinologic Society, 530 Hawthorne Place, Chicago, Ill. 60657.

Grand Rounds Schedule—Department of Surgery—Wisconsin Medical Center February 6–June 26—Time 10:00 A.M.

Sat.,	Feb.	6	Urology, VAH, 6E
"	"	13	2W, Eye, Surg. I
"	"	20	Surg. II, Neurosurg., Chest
"	"	27	C-V, Orthopedics, 6W
"	Mar.	6	Plastic, Clinical Oncology, Urology
"	"	13	VAH, 6E, ENT
"	"	20	2W, Eye, Surg. I
"	"	27	Surg. II, Neurosurg., Chest
"	Apr.	3	C-V, Orthopedics, 6W
"	"	10	Plastic, Clinical Oncology, Urology
"	"	17	VAH, 6E, ENT
"	"	24	2W, Eye, Surg. I
"	May	1	Surg. II, Neurosurg., Chest
"	"	8	C-V, Orthopedics, 6W
"	"	15	Plastic, Clinical Oncology, Urology
"	"	22	VAH, 6E, ENT
"	"	29	2W, Eye, Surg. I
"	June	5	Surg. II, Neurosurg., Chest
"	"	12	C-V, Orthopedics, 6W
"	"	19	Plastic, Clinical Oncology, Urology
"	"	26	VAH, 6E, ENT

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1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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OF WISCONSIN

Volume 64

JANUARY 1965—DECEMBER 1965

The State Medical Society of Wisconsin

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	L. W. Moody Bayfield	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	Donald J. Welter Shell Lake	Lloyd M. Baertsch Hayward	Second Tuesday 7:30 p.m.
Brown	R. M. Waldkirch 502 George St., DePere	K. C. Mickle 430 S. Webster Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	John A. Knauf Stockbridge	
Chippewa	Clifford Bowe Cadott	James L. Windeck 600 Bay St., Chippewa Falls	Second Tuesday
Clark	J. W. Koch Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	Arthur Weihe Adams	Martin Janssen 149 Linden, Adams	Every Third Month 7:00 p.m.
Crawford	James R. Wong Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	Robert A. Straughn 30 S. Henry, Madison	J. H. Morledge 30 S. Henry, Madison	Second Tuesday**
Dodge	N. H. Schulz 317 E. Lake St., Horicon	Theodore Rowan 207 S. University Ave. Beaver Dam	Last Thursday*
Door–Kewaunee	W. S. Hobson 25 S. Madison, Sturgeon Bay	David Papendick 801 Fourth St., Algoma	
Douglas	Milton Finn 1507 Tower Ave., Superior	Oscar Farias Hawthorne	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	George Wahl 616 E. Grand Ave. Eau Claire	Harry Gonlag 429 Chestnut St. Eau Claire	Last Monday
Fond du Lac	Howard Mauthe 340 Sheboygan St. Fond du Lac	John G. Parrish, Jr. 252 Sheboygan St. Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	Leo Moffett Platteville	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	Benjamin Brunkow 921 16th Ave., Monroe	Frank C. Stiles 921 16th Ave., Monroe	
Green Lake–Waushara	Russell C. Darby Wautoma	John Koch 151 N. Wis. St., Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	E. J. Hohler Mineral Point	H. P. Breier Montfort	First Thursday following first Monday
Jefferson	George Nemec Cambridge	Earl J. Netzow Lake Mills	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	R. G. Welsch 6213 10th Ave., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	Mark O'Meara 1707 Main St., La Crosse	John J. Sevenants 619 Exchange Bldg., La Crosse	Third Monday
Lafayette	D. F. Ruf 504 Wells St., Darlington	L. L. Olson 504 Wells St., Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	William Braun 412 W. Main St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoo	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. 1425 Grinnell Lane Manitowoc	Last Thursday
Marathon	George R. Hammes 808 Third St., Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	James A. Boren 1510 Main St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Robert S. Haukohl 620 N. 19th St., Milwaukee	Donald P. Babbitt 1700 W. Wisconsin Avenue Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	Michael Barton 907 Main St., Oconto	
Oneida–Vilas	George F. Pratt 617 Lake Shore, Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	Ralph S. Gage 314 Kimberly Ave. Kimberly	John H. Russell 103 W. College Ave., Appleton	Third Thursday* Elks Club
Ozaukee	T. D. Elbe 143 Green Bay Road Thiensville	Allen Misch 204 N. Washington St., Cedarburg	
Pierce–St. Croix	R. M. Hammer River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	Leo Nelson St. Croix Falls	John O. Simenstad Osceola	Third Thursday 7:00 p.m.
Portage	R. H. Slater 401 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
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Richland	James Tydrich 118 W. Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	Lester Brillman 405 E. Grand Ave., Beloit	William A. Pruett 407 Prospect St., Beloit	Fourth Tuesday
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Waukesha	Thomas E. Dugan 336 W. Wis. Ave., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Kenneth L. Haman Waupaca	Lloyd P. Maasch Weyauwega	
Winnebago	R. V. Kuhn 219 West 9th St., Oshkosh	Paul E. Wainscott 422 Broad St., Menasha	First Thursday
Wood	Richard J. Rowe 650 S. Central, Marshfield	Robert E. Bodmer 630 S. Central, Marshfield	Four times a year

* Except June, July and August.

Podiatry and WPS Contracts

IN A 1964 opinion of the Supreme Court of Wisconsin in the case entitled *State Medical Society of Wisconsin v. Charles Manson, Commissioner of Insurance*, the Society won a complete victory in its contention that podiatrists (chiropodists) are not physicians and surgeons and as such are not entitled to be paid by Wisconsin Physicians Service—the Society's nonprofit insurance plan for sickness care —for their services to subscribers and dependents.

This litigation grew out of a 1962 decree of Insurance Commissioner Manson requiring either that podiatrists be covered by WPS contracts, or that WPS refrain from offering any benefits for services in the lower leg or foot performed by doctors of medicine or anyone else. He ruled that podiatrists were "physicians and surgeons."

The Society appreciated at once the significance of any such position on the part of the Commissioner, or, for that matter, of any other public official. It would make the phrase "physician and surgeon" meaningless, with attending confusion and dangers to the general public. The Society leadership felt that the Commissioner's position was wrong and therefore had to be opposed. The court decision, which follows, vindicated the Society's position.

No. 306
August Term, 1963

STATE OF WISCONSIN: IN SUPREME COURT

STATE MEDICAL SOCIETY OF WISCONSIN,
Appellant
v.
CHARLES MANSON, Commissioner of Insurance of Wisconsin,
Respondent

Filed June 30, 1964—Franklin W. Clarke, Clerk of Supreme Court, Madison, Wisconsin.

APPEAL from a judgment, amended judgment, and an order overruling a demurrer to the answer, of the circuit court for Dane county: RICHARD W. BARDWELL, Circuit Judge. *Order reversed. Judgment reversed, and cause remanded.*

The defendant, the State Commissioner of Insurance, prevailed below in this declaratory judgment action brought by the plaintiff, State Medical Society of Wisconsin, as the operator of Wisconsin Physicians Service. The Wisconsin Physicians Service is a nonprofit insurance plan for sickness care organized pursuant to sec. 148.03, Stats. This litigation arises in connection with the contentions of the commissioner that certain language in the insurance contracts of the Wisconsin Physicians Service is misleading. Three sample insurance contracts were submitted as exhibits. The commissioner contends that there is misleading language in the three contracts regarding the services which will not be covered by the insurer.

The contract identified as Exhibit A provides in part that:

> ". . . benefits will not be provided under this contract for:
>
> "1. Any services other than those rendered by a licensed physician and surgeon."

The contract identified as Exhibit B provides in part that:

> ". . . no benefit will be provided for professional services, if:
>
> "1. Rendered by any one other than a licensed physician and surgeon; . . ."

The contract identified as Exhibit C reads in part:

> ". . . no benefit will be provided for services, care, facilities or other items, if:
>
> "4. In the form of services or supplies which are not prescribed by a physician legally licensed to practice medicine and surgery; . . ."

The amended judgment, which was entered on December 23, 1963, provides in part:

> "That the defendant have judgment declaring that such policy language as appears in Exhibits "A," "B" and "C" in the Complaint may be construed as providing the same policy benefits for treatment of the insured's feet by podiatrists, within the limits of legally authorized podiatric practice, as it provides for such treatment of the insured's feet by licensed doctors of medicine or of osteopathy."

In his memorandum decision, the trial judge stated that "the plaintiff must either cover the services of podiatrists, specifically except them or cease writing insurance policies in the State of Wisconsin."

The plaintiff began this declaratory judgment action after the commissioner issued a notice of hearing testing the right of the State Medical Society to continue to refuse, under the provisions of its policies, to pay for the services of podiatrists. There are in Wisconsin some insurance carriers whose health and accident policies do cover the services of podiatrists. This proposed administrative action by the commissioner was suspended so that the controversy might be determined judicially in this declaratory judgment action.

GORDON, J. The two principal problems presented by this appeal are (1) whether a podiatrist

is a "licensed physician and surgeon" and (2) whether the commissioner of insurance was authorized to determine that the policies of the Wisconsin Physicians Service are vague regarding the exclusion of the services of podiatrists.

1. Is a Podiatrist a Physician?

The trial court concluded that a podiatrist is not a "licensed physician and surgeon," and we fully agree with that conclusion. There are several references to the term "physician" in the Wisconsin Statutes. Sec. 990.01 (28), Stats., provides as follows:

> "Physician, surgeon or osteopath. 'Physician,' 'surgeon' or 'osteopath' means a person holding a license or certificate of registration from the state board of medical examiners."

In connection with fee splitting, the word "physician" is defined in sec. 147.225 (4) (b), Stats.:

> "'Physician' means an individual holding an unlimited license to practice medicine and surgery in Wisconsin."

Ch. 148, Stats., authorizes the State Medical Society to establish a health insurance plan, and sec. 148.03 (1) provides in part as follows:

> "Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan."

The practice of podiatry is considered in ch. 154, Stats. Sec. 134.01 expressly forecloses a podiatrist from employing "major surgery or the use of a general anesthetic." It also limits the area of treatment to the feet, except that treatment shall include "the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."

Sec. 154.04, Stats., authorized the state board of medical examiners to issue a certificate of registration to a podiatrist who is properly qualified. A podiatrist thus receives a certificate of registration rather than a license. Although not referring to podiatrists, sec. 147.17 (1) provides in part as follows:

> "No certificate of registration shall be considered equivalent to a license."

The policies issued by the appellant limit benefits to services rendered by *licensed* physicians.

The foregoing consideration of the statutory expressions necessitates the conclusion that a podiatrist is not a "licensed physician and surgeon" in Wisconsin. Even in the absence of such clarifying statutory language, we would conclude that the aforesaid quoted words, given their ordinary meaning, refer to licensed medical doctors and doctors of osteopathy, to the exclusion of others who may treat the sick but are not, in common parlance, regarded as physicians and surgeons. In our opinion, podiatry is one of the groups excluded when the ordinary and natural meaning of the words is applied.

A consideration of the case law tends to substantiate this conclusion. A comparable problem was considered by the West Virginia supreme court, which decided that a chiropodist was not a licensed physician under the statutes of that state. *Medical Care v. Chiropody Ass'n of West Virginia* (1956), 141 W. Va. 741, 93 S.E. (2d) 38. The court further concluded that reimbursement for the services of a chiropodist was not provided by the health insurance plan which was operated primarily by licensed physicians in that state.

Isaacson v. Wisconsin Casualty Asso. (1925), 187 Wis. 25, 30, 203 N.W. 918, examined the issue of whether a chiropractor was a "legally qualified physician" under the terms of a policy of insurance. The court concluded that the term "physician" was "applicable to one who practices medicine" and did not include a chiropractor.

The respondent brings to our attention the case of *Raynor v. The State* (1885), 62 Wis. 289, 296, 22 N.W. 430. There it was held that a homeopathic physician could not be convicted for a violation of a statute which prohibited one from using the title "doctor" without having a diploma from a duly incorporated medical society or college and without being a member of a state or county medical society. The *Raynor Case* was a criminal case, and it related to a type of service which was far more common in 1885 than it is today. It should also be noted that in 1885 physicians were not licensed. In our opinion, the *Raynor Case* is not controlling in the case at bar.

2. Are the Policies Misleading?

The commissioner urges that the policies of the Wisconsin Physicians Service are sufficiently misleading so that he was obligated in the furtherance of his statutory duties to require that the policies spell out the exclusion of the services of podiatrists in more express terminology. In our opinion, the policies are clear with regard to this exclusion, and it would be inappropriate for the commissioner to require further definition by the appellant.

We recognize that under secs. 148.03 (2) and 200.26 (6), Stats., the commissioner of insurance may, after a hearing and notice, withdraw his approval of any provision in an insurance policy even though he has previously approved thereof. This action may be taken if the provision is unfair, misleading or encourages misrepresentation of the insurance contract. See also sec. 201.045 (1). Notwithstanding these powers, it would be error for the commissioner to require that the State Medical Society insert in its policies an exclusionary clause for podiatrists; the legislature in sec. 148.03 authorized the creation of a sickness care plan wherein reimbursement would be limited to "any medical or

osteopathic physician licensed to practice in Wisconsin."

The existing insurance policies reasonably follow the statutory language; they are not deceptive or misleading regarding the denial of reimbursement for the services of podiatrists. They may not be construed to provide benefits for the services rendered by podiatrists.

By the Court—Order overruling the demurrer to the answer reversed. Judgment reversed, and cause remanded with directions to enter a judgment granting declaratory relief to the appellant.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 147.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 147.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes, 1963.

FEDERAL DEDUCTIBILITY OF CERTAIN HEALTH AND ACCIDENT INSURANCE

Under a recent decision *total premiums* paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, in addition to surgical-medical or hospital benefits, are deductible medical expenses for *federal* income tax purposes. Such ruling does not, of course, change the limitation permitting the deductibility only of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Previously the most that could be deducted on a policy which combined surgical-medical and hospital benefits with time loss or similar coverage was that portion of the total premium which represented an allocation of the surgical-medical or hospital benefits. In the case of the Provident plan carried by members of the State Medical Society, this was $17.00, only a minor part of the total average premium paid by member physicians.

Under the recent decision *total premiums* are deductible even though only *part* of each premium is attributable to surgical-medical or hospitalization benefits.

What Every Doctor Should Know about Workmen's Compensation

INFORMATION about the Workmen's Compensation Act is news of direct interest to virtually every physician in Wisconsin, irrespective of his specialty or location.

The law applies to more than 70,000 employers who have three or more employees. Farmers are excluded unless they employ 6 or more employees on any 20 days in a calendar year. If any one of the more than one million employees covered by the act receives an injury or disease during the course of his employment, the law makes the employer liable to provide certain indemnities and to provide or pay for such medical attention as may be needed to bring about rehabilitation.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employees under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Industrial Commission of Wisconsin. Other standards or schedules are fine for your own information, but only the Commission's standards are authoritative in Wisconsin.

★ Submit your reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and professional fees to the physician. Quite often the unexpected misfortune places the employee in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society, Box 1109, Madison, Wis. 53701, or Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 28 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Industrial Commission. To establish this claim a medical report verifying and specifying the workman's injuries or diseases and the degree of disability is necessary. The Industrial Commission and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employee with "such medical-surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances . . . as may be reasonably required to cure and relieve from the effects of the injury."

Q. How does the Industrial Commission determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer-employee relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employees under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employees and to permit the employees to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object

was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employees may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found by the Industrial Commission that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employee–patient is liable for unauthorized treatment. The Industrial Commission determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employee has complete free choice. Then the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employee does not give notice of his need for treatment, or he refuses to accept the panel physician. Then the employer has no liability and the Commission no jurisdiction to determine necessity or reasonableness.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employee, the employer, the Workmen's Compensation insurance carrier or the Commission information and reports relative to a compensation claim. The Commission explains that it is a practical necessity for physicians to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is necessary to a

proper disposition of the claim. The physician's testimony before the Commission should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employee who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employee when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Industrial Commission has the right to request a complete report on an injured employee. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other information than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employee and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Therefore, doctors must be interested in whether the injury or disease was suffered in the course of employment and arose out of the employment.

When the employer or his insurance company agrees to the fact that the injury or disease was due to the employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employee.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Commission is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employee, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employee through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Industrial Commission is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employee for payment. Likewise, where a physician treats an injured employee, and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employees?

A. In a sense, yes. The Commission is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employees who file compensation claims.

Such cases require a report (on a form supplied by the Commission) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made.

In any case in which disability results or medical expense is involved, a statement is required from the employee (on a form supplied by the Industrial Commission) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent

disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employee's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb,* having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employee has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Commission has adopted a guide table for disability due to losses of motion.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Commission worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Commission can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. As the Commission has adopted these landmarks to measure disabilities only for loss of motion, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases

Industrial Commission Guide for Estimating Disabilities

The following guide represents per cent of loss of use as compared with amputations at involved joints. This guide measures disability for loss of motion only. Other factors of disability such as pain, weakness, loss of sensation, etc., are to be established separately.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Physicians should submit their reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and of professional fees to the physician.

should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Industrial Commission. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 11, since the Commission can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Commission has adopted special forms for use of physicians. If the Commission is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Commission?

A. Approximately 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Commission has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of certified or verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as the Commission may prescribe. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Commission.

Q. Are there any suggestions for completing the forms required by the Commission?

A. The Commission needs a full report covering all factors if it is to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Commission to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. The law designates distal, second, and proximal joints. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. No standards or schedules not adopted by the Commission have the approval of the Commission. Only those adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Commission has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employee, employer, Workmen's Compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Industrial Commission, Hill Farm State Office Building, Madison, Wisconsin.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison, Wis. 53701, or to Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

TAX GUIDE AVAILABLE

The Wisconsin Taxpayers Alliance has announced that the 1965 edition of TAXES, its annually published tax guide is now available. TAXES provides easy-to-follow instructions on how to fill out both state and federal income tax returns. TAXES also includes information on all state and federal taxes levied in Wisconsin. The new tax changes made by congress and the Wisconsin legislature are incorporated in the 1965 edition.

Orders should be sent to the Wisconsin Taxpayers Alliance, Madison, Wisconsin 53703. The cost is 50 cents a copy.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which is reprinted in full beginning with page 15 hereof.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

Patients generally are classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has 3 years within which to sue for personal injuries. If a patient elects to sue on a contract rather than for alleged negligence, he has 6 years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there are doubtless sound professional reasons for retaining them longer.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

It should be mentioned here that an accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill. The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

The allegation that something is missing from the record could be of great importance when the patient is suing a physician or hospital. Since the patient does have a right of access to the use of relevant records which concern his care and treatment, it would appear to be advisable to keep the originals for at least the 6 year period.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959, which follows. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms are included in the *Interpretation* which follows but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

An Interpretation of Chapter 301; Laws of 1959

(Prepared jointly by The State Medical Society of Wisconsin and the Wisconsin Hospital Association)

1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that

the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *exeept* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by non-medical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which

NOTE

Chapter 301, Laws of 1959, as passed by the 1959 Wisconsin Legislature and signed by the Governor, created the following subsections to Section 269.57, Wisconsin Statutes, 1961:

269.57 (3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

The 1961 session of the legislature enacted the following new subsection to Section 269.57, Wisconsin Statutes:

"269.57 (5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____19____ to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by_____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from_____19____ to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

Legal Responsibilities of the Physician-Patient-Hospital Relationship

THREE SPECIFIC questions pertaining to the physician-patient-hospital relationship were recently submitted to the Society's legal counsel by the Commission on Hospital Relations and Medical Education for an opinion. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The only statutes on hospitals relate to construction, safety, standards of maternity departments, and in the case of the Fee Splitting Statute forbid a hospital to employ a physician or to engage in a fee splitting arrangement with him.

In general terms, the courts have held that a physician has a legal responsibility to his hospitalized patient to furnish that degree of professional skill which is the standard of the medical community, and to give such professional attention to the patient as the case requires. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient no longer needs his professional services, and he may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts increasingly tend to distinguish the *administrative* negligence of a hospital from the *professional* or *medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital is liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

It is also possible that both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to

determine during the course of the trial that no liability exists against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

It is therefore neither necessary nor advisable to try to generalize a joint responsibility since it is seldom present in fact.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted*, so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

In my judgment increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining", and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment.

While we find no Wisconsin cases on the point, a physician undoubtedly could, as we earlier indicated, enforce a right of contribution against the hospital in a situation in which he had been held liable and a judgment enforced against him, although the liability was partially that of the hospital.

* * *

It should be noted that the extent of legal liability of all but government hospitals is not clear at the moment in this state because the Supreme Court of

Wisconsin did not abolish the long established tort immunity rule until January, 1961, and there has not been opportunity as yet for the development of new court law in light of such abolition. It should be noted that the old rule of tort immunity still applies in government hospitals which are therefore not subject to suit for the alleged negligence of their employees.

Many points have not been covered in this opinion because they did not seem closely enough related to the questions. Thus, there has been no discussion of the contractual relationship between patient and physician. Rather it has been assumed to exist for purposes of answering the questions. No questions of adequacy of patient consent, either from the standpoint of physician or hospital, have been touched upon. It has been assumed also that hospital records were adequately maintained by the physician and by the non-medical staff under his direction, and that in other respects not specified the hospital and its employees were functioning properly and the physician was acting within the limits of the standard of professional care owed the patient.

SAVE YOUR "BLUE BOOK" ISSUE FOR FUTURE REFERENCE

This January "Blue Book" issue of the *Wisconsin Medical Journal* contains a variety of articles relating to medicolegal matters of direct concern to the physician in his relationship to governmental agencies. An annual presentation since 1924, the edition is unique among medical journals of the United States. Each one has been an outstanding legal service to members of the Society. A permanent file of these issues for future reference is recommended.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses. (Under Revision)

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor." (Under Revision)

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **Principles for Transporting the Ill and Injured**
    A guide for providing emergency transportation services, including model community and state ordinances.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The Acting District Supervisor of the Bureau of Narcotics of the U. S. Treasury approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused order forms should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin. The narcotic drugs may be disposed of by shipment, charges prepaid (shipments by mail shall not be made) to the District Supervisor, Federal Bureau of Narcotics, 817 New Post Office Building, Chicago, Illinois 60607, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs."

It is important that a widow, other members of the family and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Medical Staff Rules and Regulations as to Sterilizations

THE STERILIZATION of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

Section 46.12, Wisconsin Statutes, 1963:

"46.12 Sterilization of defectives

(1) The department [of public welfare] may appoint a surgeon and a psychiatrist of recognized ability, as experts, who (in conjunction with the superintendents of the state and county institutions who have charge of criminal, mentally ill and mentally deficient persons) shall examine inmates and patients of such institutions as to their mental and physical condition.

(2) The department may submit to the experts and to the superintendent the name of inmates or patients they desire examined, and the experts and the superintendent shall meet, take evidence and examine into the mental and physical condition of the named inmates or patients and report thereon to the department.

(3) If the experts and superintendent unanimously find that procreation is inadvisable the department may authorize an operation for the prevention of procreation.

(4) Before such operation, the department shall give at least 30 days' notice in writing to the husband or wife, parent or guardian of the inmate or patient, if known, and if unknown, to the person with whom such inmate or patient last resided.

(5) The experts shall receive as compensation $10 per day and expenses for the days consumed in the performance of their duties.

(6) The record made upon the examination shall be filed in the department; and semi-annually after the operation, the superintendent of the institution where such inmate or patient is confined shall report to the department his condition.

(7) The department shall state in its biennial report the number of operations performed under this section and the result of the operations."

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

The following opinion, furnished by legal counsel for the State Medical Society, was provided in answer to an inquiry from a hospital chief of staff and relates to the adoption of medical staff rules and regulations concerning surgery for the sterilization of patients. In substance, however, the opinion covers the law on this subject generally.

* * *

The only Wisconsin statute which specifically relates to the procedure to be followed in sterilization cases relates to criminals, the mentally ill and mentally deficient who are in state or county institutions. A copy of that statute, which is Section 46.12, is printed herein in full because it indicates the safeguards with which the Legislature surrounded the sterilization of individuals who are not able to live in a normal way in society. It seems reasonable to anticipate that if the Legislature were to enact legislation covering sterilization in noninstitutional cases, it would provide at least as careful safeguards for the "normal" majority of the public.

No court decisions have been found in Wisconsin passing on the legal aspects of the sterilization either of institutional or noninstitutional patients. The Attorney General of Wisconsin has ruled on the subject several times, however. In 1932, an Opinion was published, holding, in substance, that even if an institutionalized person were sterilized under all of the safeguards of Section 46.12 of the Wisconsin Statutes, above referred to, there was a serious question, except where the procedure was strictly therapeutic, whether the public officials who requested such surgery and the surgeon who performed the operation were not criminally liable for the common law offense of mayhem, or bodily mutilation.[1]

The Attorney General had ruled four years earlier that an incompetent person could not be legally sterilized except under Section 46.12.[2] The later opinion cited above would thus appear to be an even stricter view.

In 1938, another Opinion of the Attorney General was rendered to the effect that a vasectomy on a person who was not within one of the categories enumerated in Section 46.12 of the Statutes (in other words not in an institution for criminals, the mentally ill or mentally deficient) probably would not

subject the surgeon to criminal liability under the mayhem statute if the surgery was performed to benefit the health of the patient. Attention is invited to the careful wording of the final paragraph of the Attorney General's Opinion which stated:

> "We conclude that vasectomy in the instant case *may* be excusable by reason of necessity to preserve health."[3] (Emphasis added.)

It seems clear that a fair reading of the Attorney General's Opinions justifies the conclusion that the Attorney General of this state has taken a consistently conservative attitude toward sterilization surgery whether performed on certain types of institutionalized patients, such as the mentally deficient, or upon normal persons in the ordinary course of private medical practice.

The performance of sterilization surgery for any but clearly therapeutic reasons could subject the surgeon to criminal penalties and to civil liability for damages on suit either of the patient, spouse, parent, or guardian. Mayhem, or bodily mutilation, is a criminal offense under Section 940.21 of the Wisconsin Criminal Code, and is punishable by a fine up to $5,000, imprisonment up to 15 years, or both.

Rules and regulations on this subject should specify the number of consultants in sterilization cases and specify clinical indication for such operation.

It is recommended that at least two physicians be called into consultation before sterilization surgery is performed. That is the number required by Section 46.12 for institutional cases. Under provisions of Rule 14, of the Joint Commission on Accreditation of Hospitals, such a consultant must be well qualified to give an opinion, and a satisfactory consultation would include examination of the patient and his record and a written opinion signed by the consultant and recorded prior to the surgery, except in emergencies. Finally, the same model rule provides that to the extent possible, consultation by physicians associated in the same office should be avoided so as to reduce the likelihood of an assertion that one associate was backing up the other.

As to the enumeration of the clinical indications for such operations for sterilization, this is a matter for determination by the medical staff. An obvious example would be cancer of the reproductive system of a male or female, or the existence of venereal disease in an advanced stage. Additional examples could undoubtedly be procured from medical authorities.

REFERENCES

1. 21 O.A.G. (1932) 940.
2. 17 O.A.G. (1928) 524.
3. 27 O.A.G. (1938) 416.

Nontherapeutic Vasectomy

THE STATE Medical Society recently received the following inquiry from a hospital medical staff:

> **What are the legal implications involved if a vasectomy is considered necessary to safeguard the health of a man's wife? (In other words, if a woman for sound medical reasons should not be subjected to further childbirth, but is not physically able to withstand a surgical procedure, is it legally acceptable for the husband to subject himself to a vasectomy procedure?)**

The question was referred to legal counsel for the State Medical Society. Their opinion is as follows:

> According to our understanding the gist of your question is whether it is lawful for a physician to perform a vasectomy in Wisconsin on a male in the absence of therapeutic reasons insofar as the patient himself is concerned.

In our judgment, under present Wisconsin law, the surgeon who performed the vasectomy under the facts assumed above would subject himself to criminal and civil liability as set forth in the article preceding. With one exception, there is no law in Wisconsin which legalizes a nontherapeutic sterilization. That exception is an inmate of criminal and mental institutions who may be sterilized under provisions of sec. 46.12, of the Statutes, where certain requirements are strictly observed. We find nothing in the Wisconsin Statutes, court decisions or Opinions of the Attorney General which makes lawful a vasectomy on a healthy husband which was performed only because of the health of his wife. Sterilization is tolerated by the law only if it benefits the health of the patient on whom the surgery is performed.

As only one example of possible future complications, a later marriage by the male could be jeopardized by reason of the vasectomy.

To summarize, it is our opinion that the public policy of this state, as declared either by the Legislature or the courts, permits sterilization for clearly therapeutic purposes but does not permit the nontherapeutic sterilization of any person except as permitted by section 46.12 of the Wisconsin Statutes in the case of certain criminal and mental cases. That section clearly does not sanction the sterilization of the husband to safeguard his wife's health.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for trained practical nurses." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what

is described in the first part of subsection (2). A trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin, 53701.

Consents for Treatment of a Minor

A minor is defined by the Wisconsin Statutes as a person who is under 21. Consents to treatment are necessary for minors as well as for those over 21. Consents may be oral as well as written, but unless a physician can produce disinterested witnesses with good memories, he will do better to have the consent in writing.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless such relative has been appointed as such minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an *emergency*, a consent is *not* necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law *implies* the consent of the patient, or in the case of a minor, of his parent or guardian. BECAUSE THE LAW DOES NOT IMPLY CONSENT BEYOND THE TREATMENT ACTUALLY NECESSARY TO MEET AN EMERGENCY, THE PHYSICIAN MAY SAFELY TREAT ONLY THE EMERGENCY CONDITION ITSELF, AND NOTHING ELSE, WITHOUT ACTUAL CONSENT OF A PARENT OR GUARDIAN.

Second, an *emancipated* minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

Note: On the subject of consents generally, see 1958 *Blue Book* issue of this JOURNAL, Vol. 57, issue 1, pages 4–58.

ABORTION Protect Yourself

THE WISCONSIN Criminal Code provides a fine up to $5,000.00 or imprisonment up to three years or both for the intentional destruction of the life of an unborn child. The law states that an "unborn child" means a human being from the time of conception until it is born alive. If the life destroyed is that of an "unborn quick child" or of the mother, the imprisonment may be as high as 15 years.

A therapeutic abortion is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

If you are called upon to treat a woman who has had an attempted or completed abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given, or
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

The above two steps are recognized by the Wisconsin Supreme Court as reasonable precautions before treating a woman who has had an attempted or completed abortion.

Abortion Deaths To Be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs.

Legal counsel for the Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. Pending clarification of this point by the legislature or the courts, the physician will do well to report *all* deaths associated with abortion.

REFERENCES

1. Wisconsin Statutes, 1963, Section 940.04
2. Wisconsin Statutes, 1963, Section 966.20
3. *State v. Law* (1912) 150 Wis. 313

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Department and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1963.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

Guide for Athletic Disqualification Junior and Senior High School Level

(This guide applies particularly to football, basketball, wrestling, hockey and baseball; however, there are aspects which will be of value to physicians in determining disqualification in other sports.)

A PHYSICIAN examining junior and senior high school athletes must use good judgment in deciding whether or not to restrict a boy from competition. The purpose of this presentation is to summarize some of the important factors to help physicians arrive at a logical conclusion so that a boy is not unnecessarily prohibited from competing nor allowed to compete when he should be disqualified.

There are two major considerations for restricting persons from participation in athletics:

(1) Is there a disease or process which prevents the individual from competing fairly with normal persons?

(2) Is there a disease or process which might be aggravated by athletic competition?

Both of these are relative and circumstances alter decisions.

Conditions considered disqualifying:

(1) *Maturity*—the physician must keep this in mind when examining the athlete. The state of maturity varies greatly in adolescents of the same age. Almost all boys have reached the same stage of maturity by the junior year in high school, but many freshmen and some sophomores are not mature and should be withheld from competing with boys who are. At earlier levels, seventh and eighth grades, it is important to spot the boy who is mature and prevent him from injuring his classmates in pre-high school activities. The large boy is not always the mature boy.

Clinical judgment of maturity can best be based on the presence and degree of secondary sex characteristics—deep voice, acne, facial and body hair, axillary and pubic hair and the appearance of the external genitalia. The most helpful sign in evaluating the attainment of full sexual maturity is finding that the pubic hair has extended to the inner thighs.

(2) *Absence or Severe Disease of One of a Paired Organ*—this is an absolute contraindication for participation when it involves the eye, ear, kidney, testicle, or lung. Some may argue that the incidence of injury to these organs is small, but the obvious serious sequela, should one occur, makes this decision an easy one.

(3) *Disease of the Cardiovascular System*—here is one of the two areas of greatest uncertainty for physicians who examine athletes. There is a tendency to be over cautious. Many youngsters are denied athletic participation because of a functional heart murmur. Heart murmurs are not necessarily abnormal. The presence of a murmur is not in itself an indication to deny participation in sports. The youth with a heart murmur should have a thorough investigation to determine the reason for the murmur.

The presence of organic heart disease, especially rheumatic or congenital heart disease, is a reason for disqualification from contact sports. Those who have mitral stenosis or aortic stenosis may be seriously harmed by severe exertion. Those with cyanotic congenital heart disease ordinarily limit their activity of their own accord, but they are not competent in athletics because of their short span of endurance.

A history of rheumatic fever does not necessarily disqualify an individual for competition.

Cardiac arrhythmia, not associated with organic heart disease, is not disqualifying.

Hypertension, usually defined as persistent systolic pressure over 140 mm Hg. or diastolic pressure above 90 mm Hg., should be evaluated by repeated examinations. It is not unusual to find many high school athletes with excessive blood pressure on an emotional basis. If it does not drop readily, further evaluation is necessary to rule out coarctation of aorta, unilateral kidney disease, or some other congenital abnormality.

Also disqualifying for contact sports is peripheral vascular disease.

(4) *Hernia and Hydrocele*—disqualifying until repaired.

(5) *Nervous System*—it is not justified to allow a boy to compete in contact sports if he has had three or more periods of unconsciousness. There is a high percentage of deaths in athletes from head injuries and most of these had a previous injury before the fatal one.

(6) *Orthopedic Conditions*—this is the second area of uncertainty.

Epiphyseal diseases such as Osgood-Schlatter disease, Legg-Perthes disease, and other related osteochondroses do occur, and athletic competition should be limited while the lesions are painful.

Back pain is rare in high school athletes. Any boy who has persistent back pain should be x-rayed and closely evaluated for some congenital abnormality

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or early rheumatoid spondylitis. Congenital spondylolisthesis and Scheuermann's disease are some examples as causes of back pain and should be considered for at least temporary disqualification for contact sports. This is a physician's decision.

Some frequent abnormalities encountered are pes planus, genu valgum, genu varum, scoliosis and leg length inequality. Each of these may be mild and cause no concern. On the other hand, each of these may be of marked degree and be clinically symptomatic. If this is the case, athletic competition should be restricted. The physician must decide.

(7) *Epilepsy and Diabetes*—when under control they are not causes for restriction from athletics.

The physician must exercise careful judgment in making his decisions about participation of an individual in athletics. His decision must be based on accurate diagnosis of the condition, on reasonable knowledge of the disease process, on intimate knowledge of the many types of sports and the physical needs of each, and on his evaluation of the person. If the physician is not aware of these considerations which affect his decision, then his decision may be harmful to the athlete, to the team and to himself.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 325.23, Wisconsin Statutes, 1963.

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens. The Foundation administers these gifts in accordance with the stated desires of the donor and such gifts are deductible for tax purposes.

Among the many projects which are supported by this method is the medical student loan fund which has been given recent impetus by the donation of various surplus "Sabin on Sunday" funds from around the State and by significant donations from individuals.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

Research activity such as the Menominee County Health Survey which was presented to the fall 1964 interim session of the House of Delegates of the State Medical Society, the microscope loans, collection of medical stamps, and erecting appropriate historical markers denoting physician contributions to the history and welfare all go to make up the vast array of programs and services known as the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Charitable Contributions-1965

IT IS UNIVERSALLY acknowledged that the free giving of one's skills or substance for the benefit of others is among the noblest of human acts. What is less well known is that the Congress of the United States has fostered and encouraged individual giving far beyond the Biblical tithing. This legislative policy covers gifts to certain types of organizations whether made during life or after death of the giver. State legislatures have expressed a like policy, but have done so much more limitedly.

Because this article is concerned with the types of gifts which are deductible for income tax purposes, and such gifts are those which are made to certain categories of organizations rather than to individuals, gifts to individuals will not be discussed. This article is primarily for the information of physicians; hence corporate giving is not discussed. Since gifts made by will are so completely individual in nature, they, too, are not discussed here.

Especially during post-war years the number of organizations which solicit and need contributions has grown at a geometric rate. Earlier these consisted principally of churches, degree granting educational institutions and nonprofit hospitals. Today the number of categories which the law blankets under the phrase "charitable and cultural organizations" has been enlarged to include libraries, community centers to promote such cultural facilities as a symphony, repertory theater, ballet or opera, and, of special interest to physicians, certain medical research organizations and museums of science, art or history.

A typical physician does two kinds of giving. One is the contribution of the value of all or part of his services to needy patients, whether in his private practice or in public health centers. Closely related are his teaching services in hospitals and medical schools in the case of those who do not make this a career.

A significant aspect of contribution of professional services by a physician is that they are not recognized under the law as a form of property because they have not been converted into cash or some other form capable of valuation. For that reason, no income tax deduction is allowable for contributed services. Such contributions, however, automatically reduce the physician's time for the production of taxable income and for that reason they reduce the gross income which the donating physician earns and must report for income tax purposes.

The second type is his contributions of money or other property to one or more organizations which fall within one of the categories established by federal income tax laws. Within limits set out later, contributions to such organizations are deductible on the personal income tax return of the giver.

The balance of this article will concern itself exclusively with the federal law.

Elements of a Valid Gift

For a gift to be valid, either as a matter of general or income tax law, four elements must be present. The first is that the giver must be legally competent. Second, he must intend to make the gift without receiving any promise or thing of equivalent value from the recipient. Third, the thing given must be a form of property recognized by the law and capable of valuation. Fourth, there must be delivery of the donated property either physically or symbolically.

Income Tax Recognition of Contributions

Deductions for contributions may be taken only in the year in which a gift is made. A promise, or even a formal pledge to make a gift, is not deductible because by definition neither is a completed gift.

While contributed services are not deductible for reasons earlier noted, out-of-pocket expenses incurred by the physician or other giver in the course of donating his services are deductible provided such donated services were rendered to a charitable organization, recognized as such by the Internal Revenue Code, or to a unit of government.

Gifts in the form of cash or checks create no valuation problems except that the giver should preserve a record of the gift sufficient to satisfy the tax authorities, particularly where cash is paid.

The value of contributions of listed stocks or other securities can be determined by a broker's office. This is preferable to reliance on the quotation contained in a newspaper since the latter is always open to possibility of typographical error.

The value of such types of property as unlisted securities, land, a building, a used car or a work of art may present difficult and even complicated questions of valuation. The same is true of a gift of part or all of the income from certain securities or certain improved property, whether such gift be for a specified term of years or permanently.

The valuation of such gifts must be determined before a deduction can be taken on the giver's personal income tax return. It is also needed to complete a Treasury form required when the value of a gift exceeds $200. The most sensible procedure is for the giver to obtain a valuation of the donated property from a recognized and disinterested person or organization which has acknowledged expertness in the type of property which was given.

Future and Partial Gifts

The Internal Revenue Code permits the deductibility of gifts to take effect at some future time in

the case of two types of property. One is real estate and the second is *intangible* personal property such as a lease or a patent. Thus, if a physician gave his home to a charitable foundation, but reserved to himself and his wife the right to remain in the home for the balance of their lives, such a gift is deductible in the year in which it is made. It is measured by the fair market value of the property on the date of the gift, reduced by the dollar value of the right of occupancy reserved by the physician for himself and wife. Such value is measured by the life expectancies of the physician and his wife.

In much the same way, deductible gifts can be made of leases, securities and patents which reserve in the giver, and one or more persons designated by him, the right to income for a specified term of years or for life.

An amendment to the Internal Revenue Code effective July 1, 1964, allows no income tax deduction for charitable gifts of *tangible* personal property so long as the actual possession and enjoyment of such property remains in the giver or persons closely related to him.

As an example, if a physician gave a valuable painting to an educational foundation under a stipulation that it was to remain in his home the balance of his life, he could take no income tax deduction for the gift until he gave up the actual possession of the painting to the foundation or to an individual from whom he can't get it back. Property of this kind is not considered donated until it gets outside the possession and control of the giver or his "tax relatives."

In the absence of court decisions, the best current opinion is that the 1964 amendments continue to grant recognition to partial gifts of real estate and of both tangible and intangible personal property, the three categories discussed above. For example, a physician might give a one-fourth interest in his residence over each of four years. It appears that he could do so even with a work of art and take a deduction so long as he let such work of art out of his possession for that fraction of each year equal to the donated fraction of his title to the property. Thus if he gave a one-fourth interest in a painting to a foundation in the year 1965 he would have to provide that the painting be outside his control and that of his immediate family for at least three months of the year before he could claim an income tax deduction.

Ceilings on Giving

With two exceptions later noted, the deduction ceiling for gifts to organizations recognized by the Internal Revenue Code as entitled to be the recipients of the kinds of gifts which are deductible on the return of the giver may not exceed 20% of the "adjusted gross income" of such giver. The term "adjusted gross income" means gross reportable income reduced by those expenses attributable to the production of such income.

The first exception permits an additional deduction of 10%, which means a maximum of 30% of the adjusted gross income. The following organizations qualify for the excess between 20% and 30% of adjusted gross income in the case of the individual giver: churches, schools, certain organizations holding property for schools, nonprofit hospitals, certain medical research organizations; federal, state or local governmental units where the gift is made exclusively for public purposes; and charities or cultural organizations which normally receive a substantial part of their income from a governmental body, the general public, or both. Examples of the latter categories are the American Red Cross, the United Givers Fund, publicly or governmentally supported museums, symphonies and the like. Gifts to private charitable foundations generally do not qualify for the additional 10% deduction but do qualify under the first 20% where they have received income tax exemption from the federal government.

The second exception is the so-called "unlimited charitable deduction." Very few taxpayers qualify for this since the combination of their deductible contributions and income taxes must have exceeded 90% of taxable income, specially computed, in eight of the ten preceding years.

The 1964 amendments to the Internal Revenue Code also contain a five-year carryover provision which can be valuable where a giver exceeds his maximum in a particular year. This provision is limited, however, to the types of gifts recognizable for the excess of contributions over 20% and under 30% of his adjusted gross income. The provision does not apply to gifts which do not fall into such category, such as those to a private foundation without governmental or general public support.

Tax Savings From Giving

Broadly speaking, a person who makes a contribution which the law permits him to deduct derives two tax advantages from doing so. The first is the reduction in his income tax, and the second is a reduction in his estate tax liability. Where the property given has not increased in value over the giver's income tax cost, the gift will permit an income tax saving at whatever his federal rate is for the year in which the gift is made. Further, the property so contributed will correspondingly reduce his estate, and the saving there will be measured by the top estate tax rate or rates applicable to the valuation represented by the gift.

Thus, a gift of $10,000 cash for a taxpayer whose rate in a particular year is 55% can be made at a net cost of 45%, or $4500. If the giver were to die within several years after making the gift, the $10,000 given would represent a reduction in the assets he would otherwise have left. If his federal estate tax rate was 30% this would represent a further saving of $3,000. Thus the combination of income tax and estate tax savings, disregarding certain refinements in computation, would be $8500. This

means that on the assumed facts he made a gift of $10,000 at a net cost to himself of $1500.

Special considerations are presented where the gift is one of securities or land which have appreciated in value. Such gifts are credited at the appreciated value. There the saving to the giver is represented by his not having to pay a capital gains tax of as much as 25% on the appreciated value. In addition, the value of the property comes off the top of his estate and thus represents maximum estate tax savings.

It is also possible for a giver to obtain an income tax contribution for the appreciated portion of the donated property completely severed from that part which represents his cost. Thus, he can sell the property to an organization at his cost and make a gift of the appreciated portion.

For example, a physician might own real estate immediately adjoining a nonprofit hospital. The hospital might wish this land and the physician might wish to make a gift of the appreciated portion of its value. Assuming that the land cost him $9,000, and that it now has a fair market value of $25,000, he could *sell* the land to the hospital for $9,000 and could *donate* and take a gift deduction for the balance of $16,000 represented by appreciation in value. Such a practice is increasingly common.

An article such as this inevitably oversimplifies and does not begin to present the difficulties either of valuation or of tax computation, or the determination of what organizations are eligible for various deduction limits. A physician who embarks on a program of substantial giving, particularly where it may involve more than one year, or may be part of his estate planning, will be well advised to do such planning only with the assistance of an attorney and a certified public accountant who are experienced in these fields. Legal and tax considerations make it foolhardy for the physician to proceed without expert advice in these areas of the law and of taxation.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

1965 WISCONSIN LEGISLATURE

LIST BY OFFICE AND DISTRICT*

STATE OFFICERS

Governor	Warren P. Knowles, New Richmond	R	new
Lieutenant Governor	Patrick J. Lucey, 210 N. Whitney Way, Madison	D	new
Secretary of State	Robert C. Zimmerman, 2810 Arbor Dr., Madison	R	inc.
State Treasurer	Dena A. Smith, 1628 W. Wisconsin Ave., Milwaukee	R	inc.
Attorney General	Bronson C. LaFollette, 733 Lakewood Blvd., Madison	D	new

(Term two years; expires January 2, 1967)
(Official address: State Capitol, Madison, Wisconsin 53702)

* Sources were the newspaper accounts of the Nov. 3, 1964 election and the 1964 Wisconsin Blue Book.

Warren Knowles

Patrick Lucey

Robert Zimmermon

Dena Smith

Bronson LaFollette

BRIEF BIOGRAPHIES†

GOVERNOR

KNOWLES, WARREN P.; Rep.; 1st term; Lieutenant Governor 1955–59 and 1961–63 and State Senator 1941–55; born 8/16/08; married; attorney; LL.B. U. of Wis. 1933; World War II veteran; New Richmond.

LIEUTENANT GOVERNOR

LUCEY, PATRICK J.; Dem.; 1st term; Assemblyman, Crawford Co., 1949–51; born 3/21/18; married; real estate broker; B.A. U. of Wis. 1946; World War II veteran; 1015 Farwell Ct., Madison.

† The biographies are based on questionnaires sent out by the Wisconsin Legislative Reference Bureau, on the biographies in the *1964 Wisconsin Blue Book*, and on newspaper stories concerning the election of Nov. 3, 1964.

SECRETARY OF STATE

ZIMMERMAN, ROBERT C.; Rep.; 5th term; born 1/5/10; married; World War II veteran; mailing address, State Capitol, Madison.

STATE TREASURER

SMITH, DENA A.; Rep.; 3rd elective term since first appointed 12/5/57 to fill vacancy caused by death of husband, Warren R. Smith; born 10/19/1899; widow; 1628 W. Wisconsin Avenue, Milwaukee.

ATTORNEY GENERAL

LA FOLLETTE, BRONSON CUTTING; Dem.; 1st term; born 2/2/36; married; attorney; LL.B. U. of Wis. 1960; 733 Lakewood Blvd., Madison.

LEGISLATIVE GUIDE

With the opening of the Wisconsin Legislature in January, public health issues are again a major topic for the 1965 session. In this issue of the *Wisconsin Medical Journal* is a list of the Wisconsin constitutional officers by office and by district, both at the statehouse in Madison and the capitol in Washington, followed by maps of the legislative districts, brief biographies and pictures of the lawmakers.

Of special note is the fact that the Legislature this year, as in 1959, is split, with Democrats controlling the Assembly 52 to 48 and Republicans the Senate 20 to 12. In the Senate chambers, Sen. Frank Panzer, Brownsville, is president pro-tem, and Sen. Robert Knowles, New Richmond, is majority floorleader. In the Assembly, Robert Huber, West Allis will be speaker and Frank Nikolay, Abbotsford, majority floorleader. Minority leader for the Republicans will be Robert Haase, Marinette, who was speaker in 1963.

MEMBERS OF U.S. CONGRESS

Senator E. William Proxmire, 4613 Buckeye Rd., Madison (Term six years; expires January 3, 1969)	D	inc.
Senator Gaylord A Nelson, 5750 Bittersweet Pl., Madison (Term six years; expires January 3, 1971)	D	holdover, elected 1962

(Official address: Senate Office Building, Washington, D.C. 20025)

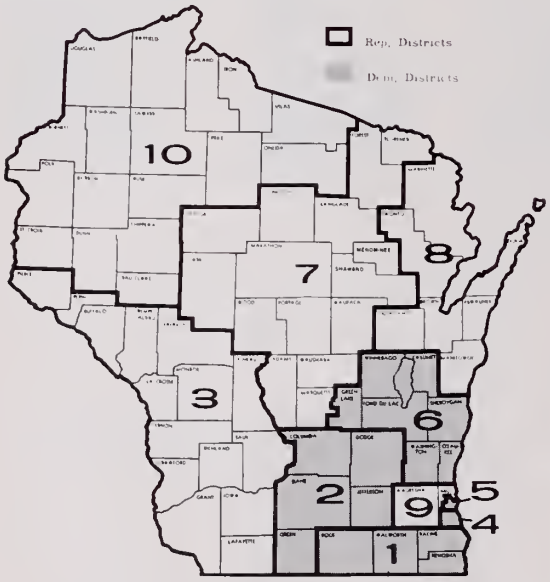
Congressmen

1st Dist.	Lynn E. Stalbaum, 904 Montclair Dr., Racine	D	new
2nd Dist.	Robert W. Kastenmeier, 300 North Water St., Watertown	D	inc.
3rd Dist.	Vernon W. Thomson, 578 East Second St., Richland Center	R	inc.
4th Dist.	Clement J. Zablocki, 3245 West Drury Lane, Milwaukee	D	inc.
5th Dist.	Henry S. Reuss, 925 East Wells St., Milwaukee	D	inc.
6th Dist.	John A. Race, 402 South Hickory St., Fond du Lac	D	new
7th Dist.	Melvin R. Laird, 313 East Third St., Marshfield	R	inc.
8th Dist.	John W. Byrnes, 412 Fairview Ct., Green Bay	R	inc.
9th Dist.	Glenn R. Davis, 2300 Springdale Rd., New Berlin	R	new
10th Dist.	Alvin E. O'Konski, Mercer	R	inc.

(Term two years; expires January 3, 1967)

(Official address: House Office Building, Washington, D.C. 20025)

U. S. CONGRESSIONAL DISTRICTS



BRIEF BIOGRAPHIES

SENATORS

Proxmire, E. William; Dem.; elected to U.S. Senate Aug. 1957 to fill vacancy caused by death of Sen. Joseph R. McCarthy, re-elected 1958 and 1964; Wis. Assemblyman 1951 session; born 11/11/15; married; former printing plant owner; B.A. Yale U. 1938, M.B.A. Harvard 1940, M.P.A. Harvard 1948; World War II veteran; 4613 East Buckeye Rd., Madison.

Nelson, Gaylord A.; Dem.; elected to U.S. Senate 1962; elected to Wis. Senate 1948, 1952 and 1956, vacated Wis. Senate seat when elected Governor in 1958, re-elected Governor 1960; born 6/4/16; married; attorney; LL.B. U. of Wis. 1942; World War II veteran; 5750 Bittersweet Pl., Madison.

CONGRESSMEN

Byrnes, John W.; 8th district; Rep.; 11th term; elected to Wis. Senate 1941; born 6/12/13; married; attorney; LL.B. U. of Wis. Law School 1938; 207 Federal Bldg., Green Bay.

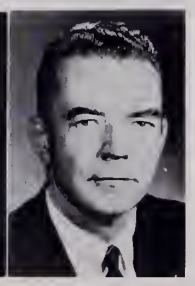
Davis, Glenn R.; 9th district; Rep.; 6th term (elected to Congress April 1957 to fill vacancy, elected for 4 succeeding terms 1949–57, elected 1964); Wis. Assemblyman 1941 session; born 10/28/14; married; attorney; B.Ed. Platteville State College 1934, LL.B. U. of Wis. 1940; World War II veteran; 2300 Springdale Rd., New Berlin.

Kastenmeier, Robert W.; 2nd district; Dem.; 4th term; born 1/24/24; married; attorney: LL.B. U. of Wis. 1952; World War II veteran; 300-½ Main St., Watertown.

Laird, Melvin R.; 7th district; Rep.; 7th term; elected to Wis. Senate 1946 to complete term of late father, re-elected 1948; born 9/1/22; married; former secy.-treas. of lumber firm; B.A. Carleton College, Minn., 1942; World War II veteran; 313 East Third St., Marshfield.

Proxmire

Nelson


Byrnes

Davis

Kastenmeier

Laird

O'Konski, Alvin E.; 10th district; Rep.; 12th term; born 5/26/07; married; former teacher, publisher and radio station owner; Ed.B. Oshkosh State College 1927. Mercer.

Race, John A.; 6th district; Dem; 1st term; born 5/12/14; married; machinist; attended U. of Wis. School for Workers; 402 S. Hickory St., Fond du Lac.

Reuss, Henry S.; 5th district; Dem.; 6th term; born 2/22/12; married; attorney; LL.B. Harvard 1936; World War II veteran; 1718 Longworth H.O.B., Washington, D.C.

Stalbaum, Lynn E.; 1st district; Dem.; 1st term; elected to Wis. Senate 1954, 1958 and 1962; born 5/15/20; married; exec. secy. of dairy co-op; World War II veteran; 904 Montclair Dr., Racine.

Thomson, Vernon W.; 3rd district; Rep.; 3rd term; Mayor of Richland Center 1944–51, Wis. Assemblyman 1935–51, Attorney General 1951–57, Governor 1957–59; born 11/5/05; married; LL.B. U. of Wis. 1932; 578 East Second St., Richland Center.

Zablocki, Clement J.; 4th district; Dem.; 9th term; elected to Wis. Senate 1942 and 1946; born 11/18/12; married; former school teacher and church organist; Ph.B. Marquette U. 1936; 3245 West Drury Lane, Milwaukee.

O'Konski

Race

Reuss

Stalbaum

Thomson

Zablocki

STATE SENATORS

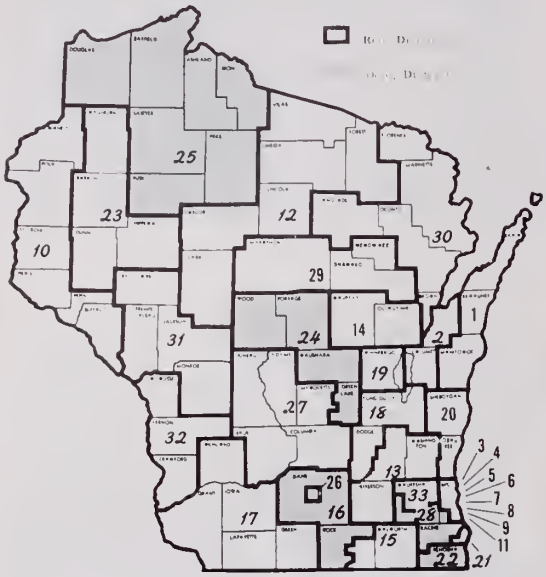
District			
1st	Alex J. Meunier, Route 1, Sturgeon Bay	R	holdover
2nd	Robert W. Warren, 200 W. Briar Lane, Green Bay	R	new
3rd	Casimir Kendziorski, 2025 S. 14th St., Milwaukee	D	inc.
4th	Jerris Leonard, 9420 N. Sleepy Hollow Rd., Bayside	R	inc.
*5th	Wilfred Schuele, 3036 N. 84th St., Milwaukee	D	new
6th	Martin J. Schreiber, 2528 W. Monroe St., Milwaukee	D	inc.
7th	Leland S. McParland, 4757 S. Packard Ave., Cudahy	D	holdover
8th	Allen J. Busby, 1673 S. 53rd St., Milwaukee	R	inc.
9th	Norman Sussman, 1232 W. Fond du Lac Ave., Milwaukee	D	holdover
10th	Robert P. Knowles, New Richmond	R	inc.
11th	Richard J. Zaborski, 713 S. 21st St., Milwaukee	D	holdover
12th	Clifford W. Krueger, 122 N. State St., Merrill	R	inc.
13th	Frank E. Panzer, Route 1, Brownsville	R	holdover
14th	Gerald D. Lorge, Bear Creek	R	inc.
15th	Peter P. Carr, 1705 Sherman Ave., Janesville	R	holdover
16th	Carl W. Thompson, Rt. 3, Stoughton	D	inc.
17th	Gordon W. Roseleip, Darlington	R	holdover
18th	Walter G. Hollander, Rt. 1, Rosendale	R	inc.
19th	William A. Draheim, 913 Hewitt St., Neenah	R	holdover
20th	Ernest C. Keppler, 909 New York Ave., Sheboygan	R	inc.
21st	Lynn E. Stalbaum, 904 Montclair Dr., Racine	D	holdover
22nd	Joseph Lourigan, 3604–19th Ave., Kenosha	D	new
23rd	Holger B. Rasmusen, 722 Franklin Ave., Spooner	R	holdover
24th	William C. Hansen, Rt. 4, Stevens Point	D	new
25th	Frank W. Christopherson, Jr., 2414 E. 6th St., Superior	D	holdover
26th	Fred A. Risser, 406 West Shore Dr., Madison	D	inc.
27th	Jess Miller, Richland Center	R	holdover
28th	Taylor Benson, 6729 Hwy. 38, Franksville	D	new
29th	Charles F. Smith, Jr., 427 Fourth St., Wausau	R	holdover
30th	Reuben LaFave, North Shore Rd., Rt. 1, Oconto	R	inc.
31st	James E. Leverich, Rt. 1, Sparta	R	holdover
32nd	Raymond C. Bice, 2406 State St., La Crosse	R	inc.
33rd	Chester E. Dempsey, Rt. 1, Hartland	R	holdover

(All terms expire second Wednesday, January; in odd-numbered districts, January, 1967; in even-numbered districts, January, 1969)

(Address during session: State Capitol, Madison, Wisconsin 53702)

* To fill unexpired term of old fifth district.

1965 WISCONSIN SENATE DISTRICTS



BRIEF BIOGRAPHIES

SENATORS

Benson, Taylor; 28th district; Dem.; 1st session; born 11/2/27; married; senior public relations representative; A.B. Notre Dame 1955; veteran World War II and Korea; 6729 Highway 38, Franksville.

Bice, Raymond C.; 32nd district; Rep.; 7th S. session (elected to S. during 4th session in A).; born 4/5/1896; widowed; retired contractor and lumber retailer; World War I veteran; 2406 State St., La Crosse.

Busby, Allen J.; 8th district; Rep.; 15th session (also served 2 in A.); born 3/6/1900; married; attorney; LL.B. U. of Wis. 1928; 1673 S. 53rd St., Milwaukee.

Carr, Peter P.; 15th district; Rep.; 6th session; married; retired wholesale grocer; 1705 Sherman Ave., Janesville.

Christopherson, Frank W., Jr:; 25th district; Dem.; 2nd session (also served 2 in A.); born 5/24/27; married; locomotive fireman and engineer; World War II veteran; 2414 E. 6th St., Superior.

Dempsey, Chester E.; 33rd district; Rep.; 12th session; born 7/20/1896; single; dairy farmer; Route 1, Hartland.

Draheim, William A.; 19th district; Rep.; 8th session; born 12/15/1898; married; retired sporting goods dealer; World War I and II veteran; 913 Hewitt St., Neenah.

Hansen, William C.; 24th district; Dem.; 1st session; born 7/4/1891; married; retired state college president; M.S. U. of Wis. 1925; Route 4, Box 211, Stevens Point.

Hollander, Walter G.; 18th district; Rep.; 5th session; born 9/8/1896; married; farmer and insurance agent; Route 1, Rosendale.

Kendziorski, Casimir; 3rd district; Dem.; 9th S. session (elected to S. during 2nd session in A.); born 12/3/1898; married; machinist and inspector; 2025 S. 14th St., Milwaukee.

Keppler, Ernest C.; 20th district; Rep.; 3rd session (also served 1 in A.); born 4/5/18; married; attorney, real estate broker; LL.B. U. of Wis. 1950; veteran World War II and Korea; 909 New York Ave., Sheboygan.

Knowles, Robert P.; 10th district; Rep.; 6th session; born 2/25/16; married; insurance and real estate business; B.S. River Falls State College 1938; World War II veteran; 335 E. 1st St., New Richmond.

Benson

Bice

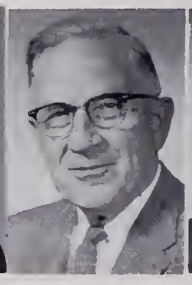
Busby

Corr

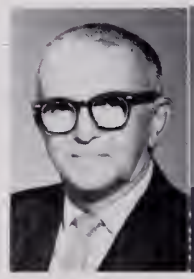
Christopherson

Dempsey

Draheim


Hansen

Hollander


Kendziorski

Keppler

Knowles

Krueger, Clifford W.; 12th district; Rep.; 9th session; born 6/24/18; married; sales manager; 122 N. State St., Merrill.

LaFave, Reuben; 30th district; Rep.; 5th session (also served 3 in A.); married; real estate broker; served in Coast Guard; North Shore Road, Route 1, Oconto.

Leonard, Jerris; 4th district; Rep.; 3rd session (also served 2 in A.); born 1/17/31; married; attorney; LL.B. Marquette U. 1955; 626 E. Wisconsin Ave., Milwaukee.

Leverich, James Earl; 31st district; Rep.; 14th session; born 12/6/1891; married; dairy farmer, fruit grower; Route 1, Sparta.

Lorge, Gerald D.; 14th district; Rep.; 6th session (elected to S. during 2nd session in A.); born 7/9/22; married; attorney; LL.B. Marquette U. 1952; World War II veteran; 147 Konkel St., Bear Creek.

Lourigan, Joseph; 22nd district; Dem.; 1st session (also served 3 in A.); born 3/19/01; married; auto worker; 3604 19th Ave., Kenosha.

McParland, Leland S.; 7th district; Dem.; 6th session (also served 7 in A.); born 12/18/1896; married; attorney; LL.B. Marquette U.; World War I veteran; 4757 S. Packard Ave., Cudahy.

Meunier, Alex J.; 1st district; Rep.; 2nd session (also served 3 in A.); born 11/9/1897; married; insurance agent; served in Army, 1918; Route 1, Sturgeon Bay.

Miller, Jess; 27th district; Rep.; 14th session; born 1884; widowed; farmer and auctioneer; Richland Center.

Panzer, Frank E.; 13th district; Rep.; 14th session (also served 1 in A.); born 9/1/1890; married; farm owner-operator; Route 1, Brownsville.

Rasmusen, Holger B.; 23rd district; Rep.; 3rd session (also served 3 in A.); born 4/26/1894; married; semi-retired pharmacist; Ph.G. Drake U., Iowa, 1916; World War I veteran; 722 Franklin Ave., Spooner.

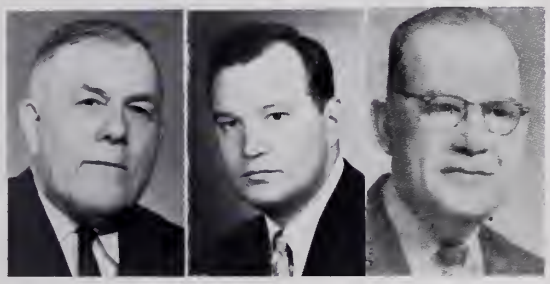
Risser, Fred A.; 26th district; Dem.; 2nd S. session (elected to S. during 3rd session in A.); born 5/5/27; married; attorney; LL.B. U. of Oregon 1952; World War II veteran; 406 W. Shore Dr., Madison.

Roseleip, Gordon W.; 17th district; Rep.; 2nd session; born 7/30/12; married; businessman; veteran of World War II and Korea; Box 167, Darlington.

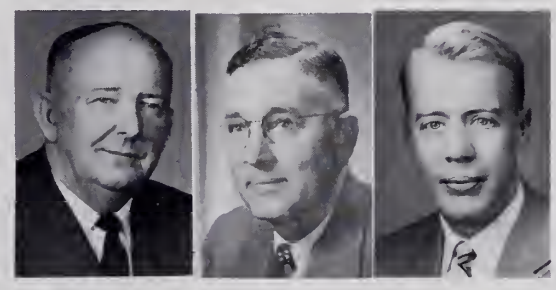
Schreiber, Martin J.; 6th district; Dem.; 2nd session; born 4/8/39; married; attorney; LL.B. Marquette U. 1964; 2528 W. Monroe St., Milwaukee.

Schuele, Wilfred; 5th district; Dem.; 1st session (also served 3 in A.); born 5/15/06; married; v.p. of water softener manufacturing co.; 3036 N. 84th St., Milwaukee.

Krueger LaFave Leonard


Leverich Lorge Lourigan

McParland Meunier Miller


Panzer Rasmusen Risser

Roseleip Schreiber Schuele

Smith, Jr.

Sussman

Thompson

Warren

Zaborski

SENATORS *continued*

Smith, Charles F., Jr.; 29th district; Rep.; 2nd session; born 7/16/18; married; attorney; LL.B. U. of Wis. 1948; World War II veteran; 427 Fourth St., Wausau.

Sussman, Norman; 9th district; Dem.; 3rd S. session (elected to S. during 2nd session in A.); born 5/26/05; married; grocery business; 1232 W. Fond du Lac Ave., Milwaukee.

Thompson, Carl W.; 16th district; Dem.; 4th S. session (elected to S. during 4th session in A.); born 3/15/14; married; attorney, home building contractor; LL.B. U. of Wis. 1939; World War II veteran; 313 E. Main St., Stoughton.

Warren, Robert W.; 2nd district; Rep.; 1st session; born 8/30/25; married; attorney; LL.B. U. of Wisconsin 1956; World War II veteran; 200 West Briar Lane, Green Bay.

Zaborski, Richard J.; 11th district; Dem.; 5th S. session; born 1/7/27; single; B.S. Marquette U. 1953; veteran of World War II and Korea; Senate Chambers, State Capitol, Madison.

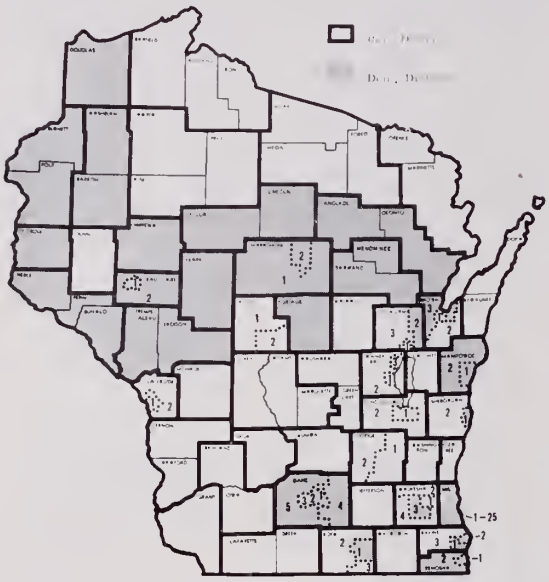
ASSEMBLYMEN

District			
Adams, Juneau, Marquette	Louis C. Romell, Rt. 1, Adams	R	inc.
Ashland, Bayfield, Iron	Bernard E. Gehrmann, 801 Prentice Ave., Ashland	R	new
Barron, Washburn	Fred J. Moser, Cumberland	D	new
Bayfield	(See Ashland)		
Brown, 1st	Jerome Quinn, 137 N. Oakland Ave., Green Bay	R	inc.
Brown, 2nd	Lawrence J. Kafka, Rt. 3, Denmark	R	new
Brown, 3rd	Cletus Vanderperren, Rt. 5, Green Bay	D	inc.
Buffalo, Pepin, Pierce	Milton S. Buchli, Rt. 1, Independence	D	new
Burnett, Polk	Harvey L. Dueholm, Luck	D	inc.
Calumet	Wilmer H. Struebing, Rt. 2, Brillion	R	inc.
Chippewa	Bruce S. Peloquin, 497 Irvine St., Chippewa Falls	D	new
Clark	Frank L. Nikolay, Abbotsford	D	inc.
Columbia	Everett V. Bidwell, 612 W. Edgewater St., Portage	R	inc.
Crawford, Vernon	Bernard Lewison, Viroqua	R	inc.
Dane, 1st	Norman C. Anderson, 3401 Dawes St., Madison	D	inc.
Dane, 2nd	Edward Nager, 840 Spaight St., Madison	D	inc.
Dane, 3rd	Robert O. Uehling, 4330 Keating Terrace, Madison	R	inc.
Dane, 4th	Jerome L. Blaska, Rt. 2, Sun Prairie	D	inc.
Dane, 5th	David O'Malley, 315 W. Main St., Waunakee	D	inc.
Dodge, 1st	Esther Doughty, 211 N. Hubbard St., Horicon	R	inc.
Dodge, 2nd	Elmer C. Nitschke, 208 Hamilton St., Beaver Dam	R	inc.
Door, Kewaunee	Lawrence H. Johnson, Rt. 2, Algoma	R	inc.
Douglas	Reino A. Perala, 824 N. 22nd St., Superior	D	inc.
Dunn	Francis L. Peterson, Boyceville	R	new
Eau Claire, 1st	Thomas H. Barland, 1616 State St., Eau Claire	R	inc.
Eau Claire, 2nd	Louis V. Mato, Fairchild	D	inc.
Florence, Marinette	Robert D. Haase, 1221 Main St., Marinette	R	inc.
Fond du Lac, 1st	Earl F. McEssy, 361 Forest Ave., Fond du Lac	R	inc.
Fond du Lac, 2nd	William S. Schwefel, Rt. 1, Oakfield	R	new
Forest, Oneida, Vilas	Paul R. Alfonsi, Minocqua	R	inc.
Grant	James N. Azim, Jr., Muscoda	R	inc.
Green, Lafayette	G. Fred Galli, 804–27th Ave., Monroe	R	inc.
Green Lake, Waushara	Franklin M. Jahnke, Rt. 3, Markesan	R	inc.
Iowa, Richland	Gregory J. Bock, Highland	R	new
Iron	(See Ashland)		
Jackson, Trempealeau	John Radcliffe, Strum	D	new
Jefferson	Byron Wackett, 100 Oak Hill Ct., Watertown	R	inc.
Juneau	(See Adams)		
Kenosha, 1st	George Molinaro, 422–44th St., Kenosha	D	inc.
Kenosha, 2nd	Earl H. Elfers, Box 86, Salem	D	inc.
Kewaunee	(See Door)		
La Crosse, 1st	D. Russell Wartinbee, 1444 Wood St., La Crosse	R	inc.
La Crosse, 2nd	Norbert Nuttelman, West Salem	R	inc.
Lafayette	(See Green)		
Langlade, Oconto	Milton McDougal, Oconto Falls	D	new
Lincoln, Taylor	Joseph Sweda, Lublin	D	inc.

District			
Manitowoc, 1st	Eugene Kaufman, 918 S. 13th St., Manitowoc	D	inc.
Manitowoc, 2nd	Everett E. Bolle, Francis Creek	D	inc.
Marathon, 1st	Ben A. Riehle, Rt. 3, Athens	D	inc.
Marathon, 2nd	David R. Obey, 515 N. 9th Ave., Wausau	D	inc.
Marinette	(See Florence)		
Marquette	(See Adams)		
Menominee, Shawano	Herbert J. Grover, 208 Presbyterian St., Shawano	D	new
Milwaukee, 1st	Mark G. Lipscomb, Jr., 5051 N. 20th St., Milwaukee	D	new
Milwaukee, 2nd	Joseph E. Jones, 4285 N. 26th St., Milwaukee	D	inc.
Milwaukee, 3rd	Angelo F. Greco, 1522 E. Windsor, Milwaukee	D	inc.
Milwaukee, 4th	Frank E. Schaeffer, Jr., 1623 W. Wisconsin Ave., Milwaukee	D	inc.
Milwaukee, 5th	Thomas M. Schaus, 2666 N. 36th St., Milwaukee	D	new
Milwaukee, 6th	Lloyd A. Barbee, 928 W. Meinecke St., Milwaukee	D	new
Milwaukee, 7th	Allen J. Flannigan, 2605 W. Auer Ave., Milwaukee	D	inc.
Milwaukee, 8th	Adrian J. Manders, 1406 S. 36th St., Milwaukee	D	inc.
Milwaukee, 9th	Edward F. Mertz, 3112 W. Silver Spring Dr., Milwaukee	D	new
Milwaukee, 10th	Frederick P. Kessler, 3004 W. Wells St., Milwaukee	D	new
Milwaukee, 11th	Raymond J. Tobiasz, 3145 S. 50th St., Milwaukee	D	inc.
Milwaukee, 12th	Albert R. Tadych, 2010 S. 15th St., Milwaukee	D	inc.
Milwaukee, 13th	Ronald G. Parys, 2554 N. Dousman, Milwaukee	D	new
Milwaukee, 14th	Robert P. Kordus, 2953 S. 12th St., Milwaukee	D	new
Milwaukee, 15th	James A. McCann, 3537 N. 95th St., Milwaukee	D	new
Milwaukee, 16th	Wayne F. Whittow, 1439 N. 49th St., Milwaukee	D	inc.
Milwaukee, 17th	John E. McCormick, 2954 S. Wentworth Ave., Milwaukee	D	inc.
Milwaukee, 18th	Louis J. Ceci, 8232 W. Winfield Ave., Milwaukee	R	new
Milwaukee, 19th	Daniel D. Hanna, 639 W. Layton Ave., Milwaukee	D	new
Milwaukee, 20th	Glen E. Pommerening, 2338 N. 88th St., Milwaukee	R	inc.
Milwaukee, 21st	Richard J. Lynch, 809 S. 120th St., Milwaukee	D	inc.
Milwaukee, 22nd	Robert T. Huber, 2228 S. 78th St., Milwaukee	D	inc.
Milwaukee, 23rd	Robert Schmidt, 6702 Crocus Ct., Greendale	D	inc.
Milwaukee, 24th	Wiilliam P. Atkinson, 1115–16th Ave., South Milwaukee	D	new
Milwaukee, 25th	Nile W. Soik, 6266 N. Santa Monica Blvd., Whitefish Bay	R	inc.
Monroe	Kyle Kenyon, Rt. 4, Tomah	R	inc.
Oconto	(See Langlade)		
Oneida	(See Forest)		
Outagamie, 1st	Harold W. Froehlich, 421 W. 6th St., Appleton	R	inc.
Outagamie, 2nd	William Rogers, 1317 Hillcrest Drive, Kaukauna	D	inc.
Outagamie, 3rd	Ervin W. Conradt, Rt. 2, Shiocton	R	new
Ozaukee	J. Curtis McKay, Cedarburg	R	inc.
Pepin	(See Buffalo)		
Pierce	(See Buffalo)		
Polk	(See Burnett)		
Portage	Norman L. Myhra, 728 Welsby Ave., Stevens Point	D	inc.
Price, Rusk, Sawyer	Willis J. Hutnik, 716 E. Third St. N., Ladysmith	R	inc.
Racine, 1st	Earl W. Warren, 2809 Virginia St., Racine	D	inc.
Racine, 2nd	Manny S. Brown, 2817 Ruby Ave., Racine	D	new
Racine, 3rd	Merrill E. Stalbaum, Rt. 1, Waterford	R	inc.
Richland	(See Iowa)		
Rock, 1st	Lewis T. Mittness, 730 N. Ringold St., Janesville	D	new
Rock, 2nd	Carolyn Blanchard, 506 Chamberlain St., Edgerton	R	inc.
Rock, 3rd	George B. Belting, 2041 E. Ridge Rd., Beloit	R	inc.
Rusk	(See Price)		
St. Croix	Donald L. Iverson, 822 Summer St., Hudson	D	new
Sauk	Walter E. Terry, Rt. 3, Baraboo	R	inc.
Sawyer	(See Price)		
Shawano	(See Menominee)		
Sheboygan, 1st	Kenneth Kunde, 2831 S. Tenth St., Sheboygan	D	inc.
Sheboygan, 2nd	Harry L. Gessert, Elkhart Lake	R	inc.
Taylor	(See Lincoln)		
Trempealeau	(See Jackson)		
Vernon	(See Crawford)		
Vilas	(See Forest)		
Walworth	George M. Borg, Jr., Delavan	R	inc.
Washburn	(See Barron)		
Washington	Frederick C. Schroeder, 523 N. 10th Ave., West Bend	R	new
Waukesha, 1st	Kenneth J. Merkel, 18300 Beverly Hill Dr., Brookfield	R	new
Waukesha, 2nd	Harold W. Clemens, 272 Lac LaBelle Dr., Oconomowoc	R	inc.
Waukesha, 3rd	Vincent R. Mathews, 530 Linden St., Waukesha	D	inc.
Waukesha, 4th	John C. Shabaz, 21425 W. Glengarry Rd., New Berlin	R	new
Waupaca	Gerald K. Anderson, Rt. 1, Waupaca	R	new
Waushara	(See Green Lake)		
Winnebago, 1st	William A. Steiger, 684 Oak St., Oshkosh	R	inc.
Winnebago, 2nd	Floyd E. Shurbert, 2904 Oakwood Lane, Oshkosh	R	inc.
Winnebago, 3rd	David O. Martin, 844 Reddin Ave., Neenah	R	inc.
Wood, 1st	Raymond F. Heinzen. Rt. 5, Marshfield	R	inc.
Wood, 2nd	Harvey Gee, 170–14th Ave. S., Wisconsin Rapids	R	inc.

(Terms expire second Wednesday of January, 1967)
(Address during session: State Capitol, Madison, Wisconsin 53702)

1965 WISCONSIN ASSEMBLY DISTRICTS



BRIEF BIOGRAPHIES

ASSEMBLYMEN

Alfonsi, Paul R.; Forest, Oneida, Vilas Counties; Rep.; 8th session; born 2/13/08; married; pres. insurance co.; World War II veteran; Minocqua.

Anderson, Gerald K.; Waupaca Co.; Rep.; 1st session; born 4/26/21; married; attorney; LL.B. U. of Wis. 1948; World War II veteran; R.F.D. 1, Waupaca.

Anderson, Norman C.; Dane Co. 1st; Dem.; 4th session; born 3/11/28; married; attorney; LL.B. U. of Wis. 1954; served in army 1946–47; 324 S. Hamilton St., Madison.

Atkinson, William P.; Milwaukee Co. 24th; Dem.; 1st session; born 5/14/01; married; civil engineer; B.S. Pennsylvania State U. 1925; World War II veteran; 1115 16th Ave., South Milwaukee.

Azim, James N., Jr.; Grant Co.; Rep.; 2nd session; born 1/17/36; married; law student; B.S. Platteville State College 1957; Muscoda.

Alfonsi

G. Anderson

N. Anderson

Atkinson

Barbee, Lloyd A.; Milwaukee Co. 6th; Dem.; 1st session; born 8/17/25; divorced; attorney; LL.B. U. of Wis. 1956; World War II veteran; 2606 West Fond du Lac Ave., Milwaukee.

Barland, Thomas H.; Eau Claire Co. 1st; Rep.; 3rd session; born 3/3/30; married; attorney; LL.B. U. of Wis. 1956; served in Army 1953–55; 131 S. Barstow St., Eau Claire.

Belting, George B.; Rock Co. 3rd; Rep.; 5th session; born 7/15/14; married; attorney; LL.B. U. of Wis. 1938; World War II veteran; 2041 E. Ridge Rd., Beloit.

Bidwell, Everett V.; Columbia Co.; Rep.; 7th session; born 10/22/1899; married; banker, ice cream manufacturer; 612 W. Edgewater St., Portage.

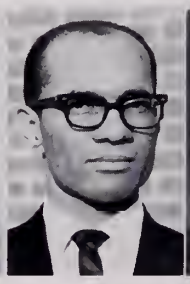
Blanchard, Mrs. Carolyn; Rock Co. 2nd; Rep.; 2nd session; born 6/13/21; widow; B.S. U. of Wis. 1943; 506 Chamberlain St., Edgerton.

Blaska, Jerome L.; Dane Co. 4th; Dem.; 4th session; born 7/4/19; married; farmer; World War II veteran; Route 2, Sun Prairie.

Bock, Gregory J.; Iowa, Richland Counties; Rep.; 1st session, born 11/2/07; married; sand and gravel producer; Box 222, Highland.

Bolle, Everett E.; Manitowoc Co. 2nd; Dem.; 3rd session; born 8/29/19; married; realtor and auctioneer; Francis Creek.

Azim



Barbee

Barland

Belting

Bidwell

Blanchard

Bloska

Bock

Balle

Borg, George M.; Walworth Co.; Rep.; 3rd session; born 12/4/34; married; v.p., local savings and loan assn.; veteran Korean Conflict; North Shore Dr., Delavan.

Brown, Manny S.; Racine Co. 2nd Dem.; 1st session; born 11/2/17; married; attorney; LL.B. Marquette U. 1952; World War II veteran; 2817 Ruby Ave., Racine.

Buchli, Milton S.; Buffalo, Pepin, Pierce Counties; Dem.; 1st session; born 8/18/10; married; farmer; World War II veteran; Rt. 1, Independence.

Ceci, Louis J.; Milwaukee Co. 18th; Rep.; 1st session; born 9/10/27; married; attorney; LL.B. Marquette U. 1954; World War II veteran; 8232 W. Winfield Ave., Milwaukee.

Clemens, Harold W.; Waukesha Co. 2nd; Rep.; 5th session; born 10/21/18; single; operates boat livery, picnic area and beach; World War II veteran; 272 Lac La Belle Dr., Oconomowoc.

Conradt, Ervin W.; Outagamie Co. 3rd; Rep.; 1st session; born 10/4/16; married; farmer and insurance agent; R.R. 2, Shiocton.

Doughty, Esther S.; Dodge Co. 1st; Rep.; 2nd session; widow; insurance and real estate business; 211 North Hubbard St., Horicon.

Dueholm, Harvey L.; Burnett, Polk Counties; Dem.; 4th session; born 1/29/10; married; dairy farmer; Luck.

Elfers, Earl H.; Kenosha Co. 2nd; Dem.; 2nd session; born 5/26/13; married; auctioneer and realtor; B.B.A. Spencerian College, Milwaukee; Box 86, Trevor..

Flannigan, Allen J.; Milwaukee Co. 7th; Dem.; 5th session; born 6/9/09; married; tool grinder; World War II veteran; 2605 W. Auer Ave., Milwaukee.

Froehlich, Harold V.; Outagamie Co. 1st; Rep.; 2nd session; born 5/12/32; single; attorney and C.P.A.; LL.B. U. of Wis. 1962; veteran of Korean Conflict; 322 E. College Ave., Appleton.

Galli, G. Fred; Green, Lafayette Counties; Rep.; 2nd session; born 5/7/02; married; manager, secy.-treas. of cheese producers co-op. assn.; 804 27th Ave., Monroe.

Gee, Harvey F.; Wood Co. 2nd; Rep.; 3rd session; born 2/29/08; married; B.A. Rollins College 1932; World War II veteran; 170 14th Ave. S., Wisconsin Rapids.

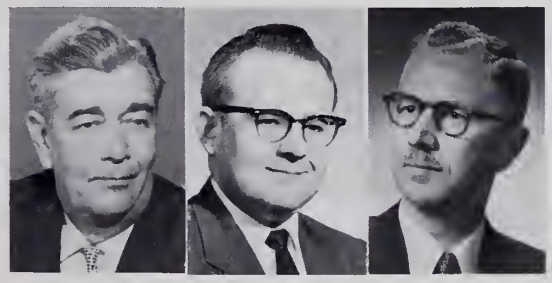
Gehrmann, Bernard E.; Ashland, Bayfield, Iron Counties; Rep.; 1st session; born 11/6/20; married; sales manager; B.S. Superior State College 1942; World War II veteran; 801 Prentice Ave., Ashland.

Gessert, Harry L.; Sheboygan Co. 2nd; Rep.; 3rd session; married; businessman, store owner; 222 Lake St., Elkhart Lake.

Borg Brown Buchli

Ceci Clemens Conradt

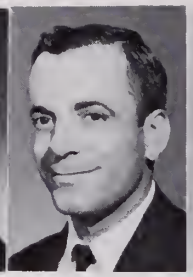
Doughty Dueholm Elfers



Flannigan Froehlich Galli

Gee Gehrmann Gessert

Grover


Greco

Haase

Hanna

Heinzen

Huber

Hutnik

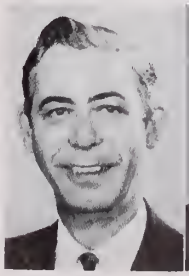
Iverson

Jahnke

Johnson

Janes

Kafka


Kaufman

Kenyon

Kessler

ASSEMBLYMEN *continued*

Grover, Herbert J.; Menominee, Shawano Counties; Dem.; 1st session; born 2/5/37; single; former management analyst, State Board of Vocational and Adult Education; M.A. American University 1963; 208 Presbyterian St., Shawano.

Greco, Angelo F.; Milwaukee Co. 3rd; Dem.; 3rd session; born 3/19/25; married; attorney; LL.B. U. of Wis. 1955; World War II veteran; 1522 E. Windsor Pl., Milwaukee.

Haase, Robert D.; Florence, Marinette Counties; Rep.; 5th session; born 5/10/23; single; attorney; LL.B. U. of Wis. 1951; World War II veteran; 1221 Main St., Marinette.

Hanna, Daniel D.; Milwaukee Co. 19th; Dem.; 1st session; born 12/5/23; married; restaurateur; World War II veteran; 639 W. Layton Ave., Milwaukee.

Heinzen, Raymond F.; Wood Co. 1st; Rep.; 3rd session; born 5/11/18; married; dairy farmer; Route 5, Marshfield.

Huber, Robert T.; Milwaukee Co. 22nd; Dem.; 9th session; born 8/29/20; married; merchandising salesman; 2228 S. 78th St., West Allis.

Hutnik, Willis J.; Price, Rusk, Sawyer Counties; Rep.; 7th session; born 3/23/15; married; school and office supplies company president; 716 E. 3rd St. N., Ladysmith.

Iverson, Donald L.; St. Croix Co.; Dem.; 1st session; born 2/3/23; married; optometrist; Doctor of Optometry, Chicago College of Optometry; World War II veteran; 822 Summer St., Hudson.

Jahnke, Franklin M.; Green Lake, Waushara Counties; Rep.; 5th session; born 4/20/1900; married; dairy farmer; Route 3, Markesan.

Johnson, Lawrence H.; Door, Kewaunee Counties; Rep.; 3rd session; born 4/26/08; married; farmer; Route 2, Algoma.

Jones, Joseph E.; Milwaukee Co. 2nd; Dem.; 2nd session; born 6/29/14; married; machinist; World War II veteran; 4285 N. 26th St., Milwaukee.

Kafka, Lawrence J.; Brown Co. 2nd; Rep.; 1st session; born 3/16/1898; widowed; trucking firm president, farm owner-operator; Rt. 3, Denmark.

Kaufman, Eugene S.; Manitowoc Co. 1st; Dem.; 2nd session; born 9/28/22; married; watchmaker, retail jeweler; graduate Elgin Watchmakers College 1948; World War II veteran; 918 S. 13th St., Manitowoc.

Kenyon, Kyle; Monroe Co.; Rep.; 5th session; married; attorney; LL.B. U. of Wisconsin 1952; World War II veteran; Rt. 4, Tomah.

Kessler, Frederick P.; Milwaukee Co. 10th; Dem.; 2nd session; born 1/11/40; single; law student; B.S. U. of Wis. 1962; 3004 W. Wells St., Milwaukee.

Kordus, Robert P.; Milwaukee Co. 14th; Dem.; 1st session; born 8/1/39; married; cost accountant; 2953 South 12th St., Milwaukee.

Kunde, Kenneth; Sheboygan Co. 1st; Dem.; 2nd session; born 7/24/16; married; public relations and business manager; World War II veteran; 2831 S. 10th St., Sheboygan.

Lewison, Bernard; Crawford, Vernon Counties; Rep.; 5th session; born 2/7/02; married; tobacco buyer, realtor, director savings and loan assn.; 11 S. Washington Hts., Viroqua.

Lipscomb, Mark, Jr.; Milwaukee Co. 1st; Dem.; 1st session; born 9/1/35; married; attorney; LL.B. Marquette U. 1964; served with Marine Corps 1957–60; 2120 West Colfax Pl., Milwaukee.

Lynch, Richard J.; Milwaukee Co. 21st; Dem.; 2nd session; born 6/11/21; married; deputy sheriff; World War II veteran; 809 S. 120th St., West Allis.

McCann, James A.; Milwaukee Co. 15th; Dem.; 1st session; born 3/7/27; married; C.P.A. and owner-manager insurance-real estate firm; B.B.S. U. of Wis 1959; veteran World War II and Korea; 3537 N. 95th St., Milwaukee.

McCormick, John E.; Milwaukee Co. 17th; Dem.; 3rd session; born 5/20/24; married; attorney; LL.B. Marquette U. 1951; World War II veteran; 2954 S. Wentworth Ave., Milwaukee.

McDougal, Milton; Langlade, Oconto Counties; Dem.; 1st session; born 7/21/17; married; livestock business; 402 Chestnut St., Oconto Falls.

McEssy, Earl F.; Fond du Lac Co. 1st; Rep.; 5th session; born 2/12/13; married; real estate broker; B.S. Marquette U. 1939; World War II veteran; 361 Forest Ave., Fond du Lac.

McKay, J. Curtis; Ozaukee Co.; Rep.; 3rd session; born 10/10/26; divorced; attorney; J.D. Northwestern U. 1957; Route 1, Box 371, Cedarburg.

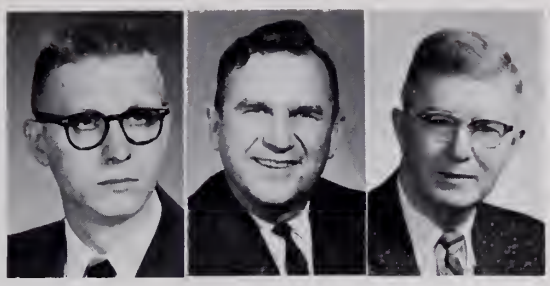
Manders, Adrian J.; Milwaukee Co. 8th; Dem.; 3rd session; born 4/17/12; married; real estate broker; 1406 S. 36th St., Milwaukee.

Martin, David O.; Winnebago Co. 3rd; Rep.; 3rd session; born 3/7/31; married; traffic analyst, paper company; B.S. U. of Mich. School of Forestry 1954; served in Engineers Corps 1954–57; 844 Reddin Ave., Neenah.

Mathews, Vincent R.; Waukesha Co. 3rd; Dem.; 4th session; born 6/8/12; married; insurance agent; B.A. Carroll College 1934; 305 South St., Waukesha.

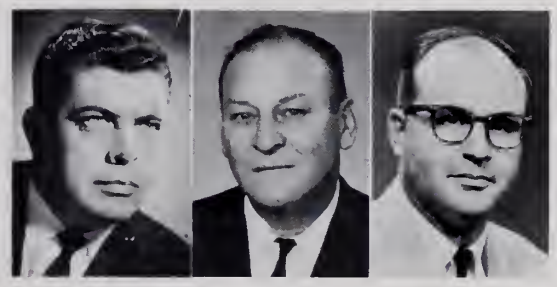
Mato, Louis V.; Eau Claire Co. 2nd; Dem.; 2nd session; born 7/20/03; married; restaurant supplies salesman; Fairchild.

Merkel, Kenneth J.; Waukesha Co. 1st; Rep.; 1st session; born 8/9/26; married; electrical engineer; engineering degree Marquette U. 1949; World War II veteran; 18300 Beverly Hill Dr., Brookfield.


Kordus Kunde Lewison

Lipscomb, Jr. Lynch McCann

McCormick McDougal McEssy


McKay Manders Martin

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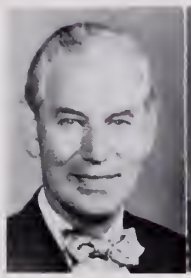
Molinaro

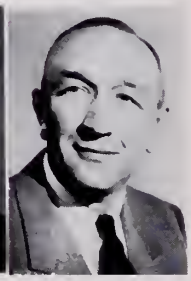

Moser

Myhro

Nager

Nikoloy

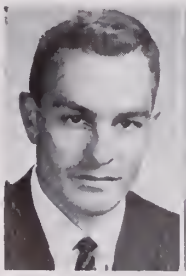
Nitschke


Nuttelmon

Obey

O'Malley

Porys


Peloquin

Perala

Peterson

ASSEMBLYMEN *continued*

Mertz, Edward F.; Milwaukee Co. 9th; Dem.; 5th session (prior sessions 1949–57); born 8/15/1890; married; semi-retired; World War I veteran; 3112 W. Silver Spring Dr., Milwaukee.

Mittness, Lewis T., Jr.; Rock Co. 1st; Dem.; 1st session; born 7/29/29; married; teacher M.E. U. of Wis. 1958; served in Army 1951–53; 730 N. Ringold St., Janesville.

Molinaro, George; Kenosha Co. 1st; Dem.; 10th session; born 10/1/02; married; auto worker, bank president; 424 44th St., Kenosha.

Moser, Fred. J.; Barron, Washburn Counties; Dem.; 1st session; born 5/2/1898; married; retired, former teacher; Ph.B. U. of Wis. 1927; World War I veteran; Cumberland.

Myhra, Norman L.; Portage Co.; Dem.; 3rd session; born 2/17/25; married; insurance business; World War II veteran; 728 Welsby Ave., Stevens Point.

Nager, Edward; Dane Co. 2nd; Dem.; 2nd session; born 7/22/27; married; attorney; LL.B. U. of Wis. 1955; served in Army Air Force 1945–47; 324 S. Hamilton St., Madison.

Nikolay, Frank L.; Clark Co.; Dem.; 4th session; born 9/1/22 married; attorney; LL.B. U. of Wis. 1948; World War II veteran; Abbotsford.

Nitschke, Elmer C.; Dodge Co. 2nd; Rep.; 9th session; born 5/20/11; married; real estate, insurance business; 208 Hamilton St., Beaver Dam.

Nuttelman, Norbert; La Crosse Co. 2nd; Rep.; 3rd session; born 3/8/11; married; farmer; Route 1, West Salem.

Obey, David R.; Marathon Co. 2nd; Dem.; 2nd session; born 10/3/38; married; B.S. U. of Wis. 1960; 515 N. 9th Ave., Wausau.

O'Malley, David D.; Dane Co. 5th; Dem.; 4th session; born 11/12/12; widowed; farmer; 315 W. Main St., Waunakee.

Parys, Ronald G.; Milwaukee Co. 13th; Dem.; 1st session; born 10/7/38; married; 2554 N. Dousman St., Milwaukee.

Peloquin, Bruce S.; Chippewa Co.; Dem.; 1st session; born 11/3/36; single; college student; 497 Irvine St., Chippewa Falls.

Perala, Reino A.; Douglas Co. 1st; Dem.; 7th session; born 8/28/15; married; attorney; LL.B. U. of Wis. 1943; 824 N. 22nd St., Superior.

Peterson, Francis L.; Dunn Co.; Rep.; 1st session; born 1/23/04; married; merchant; Box 37, Boyceville.

Pommerening, Glen E.; Milwaukee Co. 20th; Rep.; 6th session; born 9/12/27; married; attorney; LL.B. U. of Wis. 1953; 2338 N. 88th St., Wauwatosa.

Quinn, Jerome; Brown Co. 1st; Rep.; 6th session; married; merchant, real estate business; 137 N. Oakland Ave., Green Bay.

Radcliffe, John; Jackson, Trempealeau Counties; Dem.; 1st session; born 5/19/20; married; rubber company worker; World War II veteran; Strum.

Riehle, Ben A.; Marathon Co. 1st; Dem.; 6th session; born 5/15/1897; married; dairy farmer and co-op milk plant secy.-treas.; World War I veteran; Route 3, Athens.

Rogers, William; Outagamie Co. 2nd; Dem.; 2nd session; born 12/9/30; married; teacher; B.S. St. Norbert College 1958; veteran Korean Conflict; 1317 Hillcrest Dr., Kaukauna.

Romell, Louis C.; Adams, Juneau, Marquette Counties; Rep.; 8th session; born 4/7/1899; married; cattle farmer, real estate business; Edgewood Dr., Route 1, Adams.

Schaeffer, Frank E., Jr.; Milwaukee Co. 4th; Dem.; 9th session; born 2/1/05; married; brewery worker; 1623 W. Wisconsin Ave., Milwaukee.

Schaus, Thomas M.; Milwaukee Co. 5th; Dem.; 1st session; born 6/7/37; single; attorney; LL.B. U. of Wis. 1962; 2666 N. 36th St., Milwaukee.

Schmidt, Robert; Milwaukee Co. 23rd; Dem.; 3rd session; born 8/2/13; married; retired custard stand operator; 6702 Crocus Ct., Greendale.

Schroeder, Frederick C.; Washington Co.; Rep.; 1st session; born 1/10/10; married; dairy farmer; 533 N. 10th Ave., West Bend.

Schwefel, William S.; Fond du Lac Co. 2nd; Rep.; 1st session; born 10/5/02; married; retired farmer; Rt. 1, Oakfield.

Shabaz, John C.; Waukesha Co. 4th; Rep.; 1st session; born 6/25/31; married; attorney; LL.B. Marquette U. 1957; served in army 1954–56; 21425 W. Glengarry Rd., New Berlin.

Shurbert, Floyd E.; Winnebago Co. 2nd; Rep.; 4th session; born 10/30/1900; married; retired wholesale-retail meat dealer, mink farmer; 2904 Oakwood Lane, Oshkosh.

Soik, Nile W.; Milwaukee Co. 25th; Rep.; 3rd session; born 5/2/23; married; personnel supervisor, college instructor; M.B.A. U. of Wis. 1951; World War II veteran; 6266 N. Santa Monica Blvd., Whitefish Bay.

Stalbaum, Merrill; Racine Co. 3rd; Rep.; 3rd session; born 4/24/11; married; surveyor; Route 1, Waterford.

Pommerening

Quinn

Radcliffe

Riehle

Rogers

Ramell

Schaeffer, Jr.

Schaus

Schmidt

Schroeder

Schwefel

Shabaz

Shurbert

Soik

Stalbaum

Steiger

Struebing

Sweda

Tadych

Terry

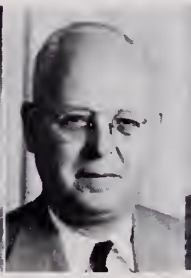
Tobiasz

Uehling

Vanderperren

Wackett

Warren


Wartinbee

Whittow

ASSEMBLYMEN *continued*

Steiger, William A.; Winnebago Co. 1st; Rep.; 3rd session; born 5/15/38; married; real estate business; B.S. U. of Wis. 1960; P.O. Box 1279, Oshkosh.

Struebing, Wilmer H.; Calumet Co.; Rep., 2nd session; born 4/2/10; married; farmer and salvage dealer; Route 2, Brillion.

Sweda, Joseph; Lincoln, Taylor Counties; Dem.; 2nd session; born 1/3/26; married; farmer; World War II veteran; Lublin.

Tadych, Albert R.; Milwaukee Co. 12th; Dem.; 3rd session; born 3/23/32; single; attorney; LL.B. Marquette U. 1958; 2010 S. 15th St., Milwaukee.

Terry, Walter; Sauk Co.; Rep.; 4th session; born 2/26/09; married; farmer; Ph.B. Notre Dame U. 1932; Route 3, Baraboo.

Tobiasz, Raymond J.; Milwaukee Co. 11th; Dem.; 3rd session; born 5/10/16; married; machine alignment worker; World War II veteran; 3145 S. 50th St., Milwaukee.

Uehling, Robert O.; Dane Co. 3rd; Rep.; 3rd session; born 4/23/15; married; attorney; LL.B. U. of Wis. 1941; World War II veteran; 4330 Keating Terr., Madison.

Vanderperren, Cletus; Brown Co. 3rd; Dem.; 4th session; born 3/4/12; married; farmer; Route 5, Green Bay.

Wackett, Byron F.; Jefferson Co.; Rep.; 7th session; born 3/21/12; married; service station operator; 100 Oak Hill Ct., Watertown.

Warren, Earl W.; Racine Co. 1st; Dem.; 6th session; born 2/25/02; married; assembler; 2809 Virginia St., Racine.

Wartinbee, D. Russell; La Crosse Co. 1st; Rep.; 3rd session; born 11/11/03; married; high school teacher; M.A. U. of Minn. 1948; 1444 Wood St., La Crosse.

Whittow, Wayne F.; Milwaukee 16th; Dem.; 3rd session; born 8/16/33; married; engineering administrator; B.B.A. U. of Wis.—Milwaukee 1963; served in army 1955–57; 1439 N. 49th St., Milwaukee.

ENDOCRINE SEMINAR

SAT., APRIL 10—MARSHFIELD

Dr. Raymond Randall, Mayo Clinic
Guest Consultant

Subject: Diseases of the Pituitary

Marshfield Clinic Foundation for
Medical Research and Education

SYMPOSIUM ON ANXIETY

WED., APRIL 14—EAU CLAIRE

Northwest Psychiatric Clinic

TELEMARK SYMPOSIUM ON ORTHOPEDICS

TUES., WED., THURS., FEB. 23, 24, 25

Cable and Mt. Telemark Ski Chalet

Featuring Mayo Clinic Faculty

Includes Ski Outing — 6 Hours AAGP Credit

Indianhead Chapter
Wisconsin Academy of General Practice

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1965, you must pay the final installment of the estimated federal and Wisconsin tax on your 1964 income. This may necessitate an amended declaration by that date if you find that you underestimated 1964 income. A final income tax return for 1964, filed before January 31, 1965, will be treated as the equivalent of an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1964 on Forms W–3 (Federal) and WT–7 (Wisconsin).
   (2) Furnish a statement to employees on Forms W–2 (Federal) and WT–9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1964.
   (3) File fourth quarterly return for 1964 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1964.
   (4) Pay income and social security taxes withheld on 1964 wages of employees if:
      (a) More than $100 was withheld in December, 1964, and not paid to government depositary earlier in January, 1965; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1964.

3. Miscellaneous:
   (1) If the total of federal income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on federal Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1965, for the respective preceding calendar quarters.
   (3) If federal income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to government depositary by the fifteenth of the following month. The amount of such withheld federal taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
   (4) Quarterly payments of Wisconsin income tax withheld must be made by the 20th day following the close of the calendar quarter unless the Wisconsin Department of Taxation requires you to report and pay on a different basis.

4. File your Wisconsin and federal partnership and personal income tax returns as early in 1965 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.

5. Estimates of Income; Quarterly Adjustments; Penalties.

The first quarterly estimate of your 1965 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax due, by April 15, 1965. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1965. As to the final payment or amendment of declaration due in January, 1966, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1965 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

ANNUAL REGISTRATION IN WISCONSIN

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, 1414 South Park Street, Madison, Wisconsin, 53715, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners and should be accompanied by the registration fee shown on that form.

ANNUAL NARCOTICS REGISTRATION

1. Register with the Bureau of Internal Revenue, Milwaukee, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1965. You are subject to penalties for overlooking either the registration or the tax.

CHANGE OF RESIDENCE

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

REMEMBER TO:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 53702, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:

   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.

e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there is no physician in attendance.
h. When a physician refuses to sign the death certificate.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 151.15, Wisconsin Statutes, 1963.

NARCOTICS

Drugs Subject to Federal Laws

Treasury Department Bureau of Narcotics Circular No. 262 dated July 25, 1962, lists drugs subject to Federal narcotic laws. The circular was printed in full in the January 1963 issue of the *Wisconsin Medical Journal.*

Annual Registration

You must register with and pay the tax to the Bureau of Internal Revenue, Milwaukee, *before* July 1 to avoid penalties.

Change of Residence

Do not fail to notify the District Director of Internal Revenue, Milwaukee, of any change in address. Failure to notify him will make you subject to penalties.

In Case of Death

The Acting District Supervisor for this area wrote from Chicago on August 27, 1963, that the following conforms with current Federal Regulations.

> "The deceased physician's Special Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused order forms should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin. The narcotic drugs may be disposed of by shipment, charges prepaid (shipments by mail shall not be made) to the District Supervisor, Federal Bureau of Narcotics, 817 New Post Office Building, Chicago, Illinois 60607, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs."

Preprinted Prescription Blanks

The Narcotics Bureau of the Internal Revenue Service reports that neither Federal law nor administrative regulation prohibits the printing of the physician's narcotic registration number on prescription blanks. However, the Narcotics Bureau prefers that physicians have their prescription blanks printed without including the narcotic registry number. According to the Bureau, if the physician follows the practice of writing in his registry number at the time narcotic prescriptions are issued, it will facilitate the easier detection of forged prescriptions.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through 1964.

general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in

its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session. The House of Delegates shall hold one interim session each year.

COMMENT: The Interim Session was directed by the House in May 1964.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions

shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Public Relations and Communications
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study,

make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each number appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty

consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 6, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 7. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 8. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to

apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction

and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1965—June 30, 1965

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION
MADISON, WISCONSIN 53703

Location	*Date*	*Location*	*Date*
Ashland	February 17 and 18	Eau Claire	April 7 and 8
Manitowoc	February 24 and 25	Chippewa Falls	April 21 and 22
Marinette	March 3	La Crosse	May 12 and 13
Racine	March 10 and 11	Sheboygan	May 19 and 20
Kenosha	March 17 and 18	Rhinelander	May 26 and 27
Stevens Point	March 24	Lancaster	June 9
Superior	April 1	Darlington	June 10

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 110 North Henry Street, Madison, Wisconsin 53703.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Manono houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 200 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

WPS Protection

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adams:
Janssen, M. L.
Weihe, A. R.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Hopkins, R. G.
March, J. F.
Papendick, D. E.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Curran, W. P.
Dorzeski, E. F.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Gillespie, C. J.
Lambert, J. W.
McKenna, E. A.
McKenna, J. E.
Moore, G. E.
Roth, E. J.
Seilin, Josef

Appleton:
Anderson, J. G.
Benton, J. L.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cooper, H. G.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Fenlon C. E.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Green, C. J.
Gross, H. T.
Hale, William H.
Hamel, H. H.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kitzerow, E. B.
Konz, S. A.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
Marshall, F. S.
Marshall, V. F.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, E. F.
Miller, E. J.
Mueller, G. F., Jr.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Plouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Richards, W. R.
Russell, J. H.
Santos, G. P.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Slette, D. R.
Swanton, M. E.
Taylor, A. C.
Veum, J. S.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

Arcadia:
Chisholm, T. P.
Comstock, Elizabeth
Schlagintweit, H.

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Grigsby, R. O.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Larson, H. H.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, W. J.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O G.
Thieda, E. S.

Baldwin:
May, J. A.
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Pearson, C. R.
Siebert, J. T.

Barron:
Macmillan, D. G.
Strang, C. J.
Whaley, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Qualls, C. L.
Richards, W. G.
Roberts, R. R.
Rowan, T.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Clark, D. M.
Crockett, W. W.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Freeman, W. S.
Glesne, O. G.
Gunderson, R. H.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qui, F. L.
Raube, H A.
Sanderson, R. J.
Scholten, W. A., Jr.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Tuftee, A. O.
Twyman, A. H.
Woodington, G. F.

Berlin:
Koch, H. C.
Koch, J. C.
Osicka, S. R.
Schmidt, E. M.
Seward, L. J.
Sievers, D. J.
Stone, G. C.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black River Falls:
Daniells, A. S.
Holder, R. L.
Krohn, Eugene
Krohn, J. I.
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Brandon:
Adams, H. G.

Brodhead:
Hein, W. E.
Stuessy, M. W.

Brown Deer:
Kohne, B. D.

Brookfield:
Benoit, M. P.
Mann, D. H.
McKenzie, J. R.
Meves, T. F.
Pavlic, R. S.
Roth, D. A.
Stoklos, Michael
Teresi, J. L.
Werts, K. G.
Whalen, G. E., Jr.
Wood, D. L.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Erickson, L. W.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
Mastalir, L. O.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

* As of December 31, 1964.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.

Campbellsport:
Graves, R. H.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Powell, J. E.

Chilton:
Humke, E. W.
Humke, K. R.
Knauf, J. W.
Knauf, R. E.

Chippewa Falls:
Brown, F. J.
Dahl, D. A.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Smith, H. E.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Caskey, H. S.
Reichle, R. I.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Koch, James W.
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Earnhart, Harlan
Felland, O. M.

Colgate:
Domann, W. G.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E.

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Abrams, J. E.
Chelius, C. J.
Fine, J. M.
Frederick, J. J.
Homsey, J. J.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Marcich, Z. P.
Oddis, N. A.
Pizer, J. A.
Potos, W. B.
Rosenbaum, M. K.
Rufflo, R. A.
Tabet, R. C.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.

Darien:
Truex, G. O., Jr.

Darlington:
McConnell, E. D.
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.
Wade, Chester

Delavan:
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Connolly, J. E.
Hering, G. V.
Michna, C. T.

De Pere:
Elders, W. F.
Keiser, O. S.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.

Durand:
Bryant, R. J.
Springer, J. P.

Eagle River:
Bartley, V. H.
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.
Pace, A. J.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Angell, D. C.
Aronson, Willard
Bates, P. J.
Beckfield, W. J.
Beebe, G. W.
Bjurstrom, R. O.
Brousseau, E. R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Carlson, S. D.
Dibble, J. B.
Falstad, C. H.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Graber, R. E.
Griffith, D. R.
Haag, A. F.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Stewart, K. E.
Strand, R. C.
Thimke, H. E.
Tobin, J. M.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Pearce, L. W.
Rawlins, J. A.
Rogers, R. J.
Sablay, Nonito
Sorenson, E. D.

Ellsworth:
Jonas, E. R.

Elm Grove:
Dall, G. A.
Denio, M. J., Jr.
Erwin, C. P.
Erwin, C. J.
Grade, J. O.
Hanson, E. R.
Mateicka, W. E.
Millington, P. E.
Myers, S. C.
Redlin, R. R.
Rouman, W. C.
Settimi, A. L.
Wisniewski, J. H.
Zurheide, H. J.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Hitselberger, J. F.
Huebner, J. S.
Hutter, A. M.
Jones, L. E.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Liewen, B. E.

Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sigalove, W. H.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Sargent, C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Russell, J. C. H.
Vognar, S. F.
Voytek, J. J.

Fox Lake:
Ferguson, E. C.
Glasson, L. G.

Fox Point:
Martin, D. H.
Peters, L. M.
Sibberman, Jack
Thompson, L. H.

Franksville:
Mac Vicar, E. L., Jr.

Frederic:
Andrews, W. C.
Fischer, W. A.
Moore, R. M.
Schwab, D. F.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Klutzow, F. W.

Glendale:
Brazy, R. R.
Truszkowski, A. J.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Grafton:
Fueredi, Adam
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Hartzell, R. L.

Green Bay:
Angus, D. C.
Austin, S. D.
Belson, M. J.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Bramschreiber, J. L.
Brault, R. G.
Brusky, A. H.
Brusky, E. S.
Brusky, S. F.
Caffrey, J. F.
Christensen, P. D.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Danaher, H. H.
Denys, G. F.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Griggs, S. L.
Groessl, P. J.
Gruesen, R. A.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Halloin, J. E.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Hoops, H. J., Jr.
Icks, K. R.
Jensen, R. E.
Johnston, R. E.
Kaftan, G. R.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Leicht, T. R.
Le Mieux, G. E.
LeTellier, M. S.
Levitas, I. E.
Lynn, T. E.
Mackey, J. P.
MacMullen, Wallace, II
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Milson, B. I.
Milson, Louis
Milson, S. E.
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, George
Nellen, J. W.
Neu, V. F.
Nicolaus, W. H.
Ottum, J. A.
Oudenhoven, R. C.
Philipp, L. D.
Quigley, L. D.
Rahr, H. C.
Randall, J. H.
Robb, J. J.
Rose, R. J.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Slightam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoll, W. M.
Sullivan, Donel
Theiler, G. J., Jr.
Theisen, J. K.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Von Heimburg, Roger
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Kuglitsch, E. F.

Green Lake:
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Alstadt, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Grosshandler, S. L.
Joseph, W. A.
La Susa, T. J.
Pierce, D. F.
Rath, E. K.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Arrambide, George
Hoffmann, J. G.
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Krueger, E. R.
Rosmann, H. K.
Sahs, M. H.
Wyant, M. E.

Haywood:
Stang, H. M.

Hazel Green:
Farbstein, M. E.
Klein, G. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.
Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Iola:
Wood, C. F.

Jackson:
Albrecht, J. E.

Janesville:
Apfelbach, G. L.
Baumgartner, M. M.
Betlach, Dorothy M.
Betlach, Eugene H.
Chicks, C. O.
Clark, W. T.
Cooper, T. H.
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Freitag, S. A.
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Koch, V. W.
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Neeno, Katsumi
Nolta, R. T.
Nuzum, T. O.
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Overton, R. S.
Pember, J. F.
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Lake Geneva:

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Eickhoff, E. C.

Laona:

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Little Chute:

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Van Lieshout, F. X.

Lodi:

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Madsen, R. E.
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Schmidt, C. S.
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Shropshire, R. W.
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Walton, J. D.
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Weatherhogg, C. R.
Weinstein, A. B.
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Williams, D. L.
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Wolberg, W. H.
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Wyner, S. F.
Ylitalo, W. H.
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Manitowoc:

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Perry, T. K.
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Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
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Rice, R. L.
Richtmyer, E. R.
Rife, C. S.
Rikkers, D. F.
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Rodenbeck, A. F.
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Roncke, G. J.
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Rosenbaum, F. F.
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Rosenthal, Samuel
Ross, F. A.
Rothman, L. E.
Rotter, E. J.
Rouman, W. C.
Royce, Owen, Jr.
Ruch, D. M.
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Rueth, J. E.
Ruff, L. L.
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Ryan, P. W.
Ryan, T. E.
Sable, M. H.
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Saichek, R. P.
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Saketos, T. P.
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Sander, O. A.
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Santer, D. G.
Sargent, J. W.
Sass, L. C.
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Sauter, K. E.
Savino, P. R.
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Schmit, Louis
Schmitz, J. T.
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Scholter, E. A. W.
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Schubert, F. J.
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Schuler, F. X
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Schumacher, H. S.
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Servis, L. T.
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Southcott, W. C.
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Stockland, Leo
Stoddard, F. J.
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Studley, W. H.
Stula, G. D.
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Tonkens, S. W.
Torcivia, S. S.
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Turner, C. R.
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Urban, F. H.
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Uszler, L. B.
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Ludden, H. D.

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Zupanc, E. A.

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Breier, H. P.

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Hockett, A. J.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Morrison, M. T.

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Rosenkranz, W. E.
Zarbock, F. M.
Zwisler, E. E.

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Ackerman, E. T.
Klockow, W. E.

Muskego:
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Kelm, G. J.

Neenah:
Alt, T. H.
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Hardie, G. H.
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Pansch, F. N.
Petersen, G. W.
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Ryan, D. J.
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Smith, F. H.
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New Berlin:
Clark, R. A.
De Vault, M. L.
Hartwick, J. P.
Komar, R. R.
Schofield, Raymond
Selle, F. S.
Yount, L. J.

New Franken:
Looze, J. A.

New Glarus:
Hicks, E. V.
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.
Pellicer, J. G.

New Lisbon:
Koch, C. B
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

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Allen, J. S.

Oakfield:
Ehrhardt, A. A.

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James, W. D.
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Matt, J. R.
Miller, G. D.
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Schuele, D. T.
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Omro:
Peck, D. D.
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Kellogg, L. S.

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McNair, E. R.

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Danforth, H. J.
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Enrich, P. S.
Graber, L. D.
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Greenwood, Ben. S.
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Hahn, W. V.
Haines, M. C.
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Hughes, J. B.
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Kronzer, J. J.
Kuhn, R. V.
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Payne, J. C.
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Scheuermann, N. M.
Steen, M. H.
Stone, L. H.
Wagner, R. F.
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Williams, E. B.
Winter, E. F.
Wolfgram, R. C.
Wright, E. N.
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Knutson, Oscar
Leasum, R. N.

Owen:
Phillips, T. A.

Palmyra:
Handeyside, R. G.

Pardeeville:
Westcott, T. S.

Park Falls:
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Leahy, J. D.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
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Pewaukee:
Kelly, J. P.

Phelps:
Wolcott, R. R.

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Rens, J. L.

Plain:
Fowler, Paul H.
Galarnyk, I. A.

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Moffett, J. L.
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Steidinger, C. L.
Stuessy, M. F.

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Docter, C. W.

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Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Steffan, L. J.
Weisse, H. A.

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Cooney, R. T.
Henney, C. W.
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Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
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Tierney, E. F.
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Henkle, R. F.
Kauth, C. P.
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Savage, G. F.
Wallestad, P. W.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
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Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Love, R. G.
Satter, O. E.
Shapiro, H. L.
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Bishop, P. R.
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Roemhild, F. N.

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Burch, V. J.
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Deocampo, E. D.
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Nickelsen, J. R.
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Olson, E. S.
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Pinkus, W. H.
Pope, F. W.
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Rothenmaier, G. L.
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Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Skow, G. D.
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Smollen, W. J.
Smullen, G. H.
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Wright, R. S.

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Horvath, D. C.

Random Lake:
Russell, J. A.

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Hanko, J. E.
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Simeon, R. G.
Stadel, E. V.
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Osborne, R. R.
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Schuler, W. H.

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Olson, M. H.

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Quinn, G. A.
Reinemann, J. M.
Schlichting, J. E.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Flogstad, Duane
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Davis, D. P.
Pfeiffer, O. W.
Vlazny, F. J.

Shullsburg:
Hoesley, H. F.

Siren:
Sun, K. C.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
McFadden, Wayne
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Roob, D. M.
Spencer, G. N.
Theisen, C. E.
Turgai, Valerio
Zahl, W. H.

South Wayne:
Creasy, L. E.

Sparta:
Albrecht, P. G.
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Spring Valley:
Jurisic, Anthony

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Dunn, A. G.
Eckberg, R. A.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kohn, A. M.
Litzow, J. A.
Milano, Angelo
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Sanders, R. H.
Schierl, A. G.
Sciarrone, F.
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stone Lake:
Marlewski, C. R.

Stoughton:
Hermundstad, O. A.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Dorchester, D. E.
Evenson, R. G.
Grota, H. D.
Hobson, W. S.
Sheets, W. G.
Wagener, N. R.

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Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Russell, W. T.

Superior:
Anderson, R. T.
Doyle, T. J.
Ekblad, V. E.
Finn, Milton
Foderick, J. W.
Fruehauf, R. P.
Giesen, Conrad W.
Johnson, F. G., Jr.
Knights, J. A.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mann, Robert
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
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Sincock, H. A.
Stack, E. G., Jr.
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Weisberg, J. H.

Suring:
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

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Elbe, T. D.
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Kim, K. S.
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Connolly, James
Neis, F. P.

Three Lakes:
Cochrane, W. L.

Tigerton:
Helse, L. F.
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Tomah:
Bryan, A. W.
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
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Ryan, C. J.

Tomahawk:
Baker, R. G.
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Slocumb, C. O.

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Kaner, S. L.
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Martin, R. E.
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Zlatnik, A. P.
Zlatnik, P. A.

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Davies, Gwilym
Desch, C. A.
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Edson, J. D.
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Gallo, G. L.
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Guy, J. R.
Hillan, D. D.
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Kritter, A. E.
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Motzel, A. J., Jr.
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Promer, J. E.
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Wood, C. A.
Zietlow, F. G.

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Marquis, W. R.
Ptacek, L. J.

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Boudry, M. O.
Haman, K. L.
Salan, J. R.
Salan, Sam
Steiner, J. H.

Waupun:
Barajas, Rafael
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Hull, H. H.
Hull, S. B.
Petters, W. J.
Pyle, R. L.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Andrews, G. R.
Bachhuber, G. J.
Backer, G. L.
Balliet, C. M.
Bartholomew, R. D.
Becker, W. T.
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Fechtner, H. H.
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Freeman, J. M.
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Hendrickson, A. O.
Hendrickson, W. O.
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Holmes, G. W.

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Juers, R. H.
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Kordiyak, George
Kramer, J. D.
Larsen, R. B.
Locher, W. G.
Ludwig, E. P.
Mallery, O. T.
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Miller, T. O.
Miller, W. C.
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Shannon, R. C.
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Smith, B. K.
Songe, R. A.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
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Thackeray, R. C.
Trumbo, J. K.
Uecker, R. L.
Williamson, L. M.
Wilson, O. M.
Yoran, C. M.

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De Guzman, E.

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Darby, R. C.
Slattery, F. G.

Wauwatosa:
Appleby, K. B.
Arneth, J. J.
Baker, W. V.
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Beffel, J. M.
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Berglund, G. A.
Bookhamer, J. W.
Boyle, R. W.
Burgardt, G. F.
Calvy, D. W.
Curtis, William C.
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Flanary, J. R.
Flanary, L. M.
Harkness, J. W.
Headlee, C. R.
Higley, R. A.
Jenk, L. F.
Josephson, Morton
Kegel, T. A.
Kehlnhofer, F. H.
Klopfer, W. P.
Kocovsky, E. C.
Kradwell, W. T.
Liefert, K. A.
Lorton, W. L.
Malloy, P. J.
Marck, Abraham
Martens, E. W.
McDermott, J. F.
McGrath, D. J.
Nordin, P. F.
O'Connell, James R.
Osgood, C. W.
Patterson, R. H.
Pendergast, T. J.
Pilliod, J. V.
Ricciardi, I. J.
Ruskin, B. A.
Russell, R. J.
Schmidt, E. J.
Schulte, W. J.
Schwartz, W. R.
Selfert, K. A.
Stoehr, B. J.
Stuhler, J. D.
Turrell, E. S.
Twelmeyer, H. F.
Wells, R. K.
Winters, K. J.
Worm, G. J.

Webster:
Maas, D. A.

West Allis:
Aprahamian, C.
Bertolaet, E. E.
Collins, E. G.
Couch, J. R.
Couch, T. T.
Cramer, R. P.
Everts, E. L.
Fick, K. R.
Frederick, R. H.
Fulton, J. W.
Heinan, F. C.
Hermann, W. C.
Jochimsen, M. A.
Malensek, M. C.
Miner, D. L.
Nefches, M. S.
Rumhoff, Gordon
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Stern, R. S.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.
Wind, J. L.
Zenz, Carl
Zimmer, J. F.
Zimmer, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F.
Bush, F. I.
Driessel, R. H.
Frankow, R. O.
Gibson, R. D.
Grundahl, A. T.
Nielsen, W. A.
Olsen, E. H., Jr.
Scheunemann, W. E.
Schulz, J. H.
Sorensen, R. F.
Speckhard, M. E.
Struck, Eleanor C.

Westby:
Bland, P. T.

West De Pere:
Gutheil, D. A.
Lenz, R. B.

West Salem:
Gersch, G. P.
Goedecke, R. H.
Gundersen, S. B.
Lloyd, B. E.
Morris, D. L.
Swarthout, Edyth C.
Wakefield, G. F.

Westfield:
Demke, R. L.
Fredrick, H. Y.

Weyauwega:
Maasch, L. P.

Whitefish Bay:
Brady, J. J.
Farrell, H. J.
Gruender, J. E. M.

Whitehall:
Hanley, L. L.
MacCornack, R. L.
Simons, N. S.

Whitewater:
Ambrose, S. H.

Wild Rose:
Hong, Roy
Kjentvet, R. A.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Bachhuber, H. M.
Bobowski, C. D.
Denzel, H. A.
Gruener, C. E.
Gursoy, Erdaly
Kubiak, Mary K.
Loftus, E. R.
Miezlo, Stanley

Winneconne:
Effenhauser, M.
McDonald, D. H.

Wisconsin Dells:
Broderick, C. F.
Conley, H. L.
Gissal, F. W.
Houghton, J. H.

Wisconsin Rapids:
Arendt, C. J.
Arendt, N. W.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Johnson, R. L.
Lucas, A. M.
Nelson, W. L.
Pomainville, H. G.
Pomainville, L. C.
Schaller, J. W.
Shapiro, David
Shields, G. G.

Withee:
Johnson, J. W.

Wonewoc:
Baker, H. P.

Wood:
Dessel, B. H.
Golbert, T. M.
Henschel, A. B.
Henschel, E. O.
Jerofke, Alfred
Kory, R. C.
Leitschuh, T. H.
Levin, J. J.
Mahaffey, C. H.
Remus, C. J.
Ruetz, P. P.
Stengel, B. F.
Unger, J. D.

Woodruff:
Hiatt, W. R.

Woodville:
Heiser, P. Arthur

Wrightstown:
Vande Loo, F. B.

Out-Of-State Members

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Banyai, A. L. ---------- Chicago, Illinois
Barber, J. L. ---------- Stanford, California
Barcome, D. F. ---------- Houston, Texas
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Beil, E. J. ---------- St. Petersburg, Florida
Belcher, C. H. ---------- Hilo, Hawaii
Belshe, J. C. ---------- Minneapolis, Minnesota
Belza, Janusz ---------- Palo Alto, California
Bernhard, V. M. ---------- Houston, Texas
Bittle, K. A. ---------- Patton, California
Bremer, E. M. ---------- North Ridge, California
Brown, W. M., Jr. ---------- Altadena, California
Costello, W. H. ---------- Phoenix, Arizona
Cramer, G. G. ---------- Minneapolis, Minnesota
Cutshall, R. A. ---------- Burnsville, Minnesota
Davee, Chalmer ---------- Columbia, South Carolina
Deering, H. C. ---------- Norwalk, California
Doyle, R. F. ---------- Wadsworth, Kansas
Duer, G. R. ---------- Winter Haven, Florida
Duxbury, W. J. ---------- Minnesota
Fieber, W. W. ---------- Omaha, Nebraska
Fink, D. W. ---------- Denver, Colorado
Fink, J. N. ---------- Skokie, Illinois
Fitzpatrick, P. J. ---------- Security, Colorado
Goodfriend, R. B. ---------- White Plains, New York
Habermann, J. H. ---------- Fort Dodge, Iowa
Hansen, R. L. ---------- Rochester, Minnesota
Heeb, H. J. ---------- Howey in the Hills, Florida
Higgins, C. K. ---------- St. Louis, Missouri
Hiller, R. I. ---------- Chicago, Illinois
Hoehne, K. A. ---------- Mantcno, Illinois
Huth, E. P. ---------- Englewood, Florida
Jacobi, D. E. ---------- San Francisco, California
Jascula, J. H. ---------- San Francisco, California
Johnson, H. C. ---------- Eugene, Oregon
Kelley, G. F. ---------- Berkeley, California
Klatt, K. M. ---------- Baltimore, Maryland
Korkos, G. J. ---------- St. Louis, Missouri
Lee, J. M. ---------- San Diego, California
Lende, R. A. ---------- Denver, Colorado
Lindner, Anton ---------- Oklahoma City, Oklahoma
Ludwig, A. S. ---------- Brooklyn, New York
MacGillis, A. J. ---------- Rochester, New York
Mallin, Isadore ---------- Chicago, Illinois
Marks, J. R. ---------- Pasco, Washington
Matus, Simon ---------- St. Louis, Missouri
Metcalf, G. S. ---------- Lewiston, Idaho

Miller, J. R. ---------- New Orleans, Louisiana
Morgan, R. L. ---------- Phoenix, Arizona
Murphy, J. F. ---------- Columbia, South Carolina
Nickels, R. J. ---------- Saginaw, Michigan
O'Donnell, M. J. ---------- Wadsworth, Kansas
Pember, A. H. ---------- Lake Wales, Florida
Peterman, M. G. ---------- Washington, D. C.
Peterson, F. N. ---------- Wayland, Massachusetts
Peterson, L. W. ---------- Dania, Florida
Randall, M. W. ---------- Glenwood Springs, Colorado
Richany, S. F. ---------- Durham, North Carolina
Roller, M. C. ---------- Plainfield, Indiana
Rothe, C. A., Jr. ---------- Warren, Pennsylvania
Royce, M. E. ---------- Calexico, California
Sargeant, H. W. ---------- Long Prairie, Minnesota
Schultz, C. L. ---------- Roswell, New Mexico
Stebbins, W. W. ---------- St. Petersburg, Florida
Terry, R. E. ---------- Las Vegas, New Mexico
Theil, G. B. ---------- Iowa City, Iowa
Thompson, H. G., Jr. ---------- Morgantown, West Virginia
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Van Riper, H. E. ---------- Yonkers, New York
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Way, T. F. ---------- Merced, California
Webster, J. G. ---------- Andover, Massachusetts
Werba, D. R. ---------- Phoenix, Arizona
Weston, E. L. ---------- Academy, Colorado
Wheeler, Robert M. ---------- Fort Lauderdale, Florida
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Zaun, J. J., Jr. ---------- Mesa, Arizona

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Kratchovil, C. H. ---------- Holloman AFB, New Mexico
Kreissl, L. J. ---------- Santa Rosa, California
Kroncke, G. M. ---------- FPO, San Francisco, California
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Lasser, A. E. ---------- Cincinnati, Ohio
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Campbell, W. B. ---------- Waukesha
Christensen, F. C. ---------- Racine
Clark, W. T. ---------- Janesville
*Comstock, Elizabeth ---------- Arcadia
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Eck, G. E. ---------- Lake Mills
Epley, O. H. ---------- New Richmond
Fazen, L. E. ---------- Racine
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Forkin, G. E. ---------- Menasha
Gramling, J. J. ---------- Milwaukee
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Hammond, F. W. ---------- Manitowoc
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Herner, Wm. L. ---------- Milwaukee
Holbrook, A. T. ---------- Milwaukee
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Kay, H. M. ---------- Madison
Keland, H. B. ---------- Racine
Kleinboehl, J. W. ---------- Mercer
Knutson, Oscar ---------- Osseo
*Koehler, A. G. ---------- Oshkosh
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Leonard, C. W. ---------- Fond du Lac
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Rolfs, T. H. ---------- Milwaukee
Schmit, Louis ---------- Milwaukee
Schweitzer, G. J. ---------- Milwaukee
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*Sincock, H. A. ---------- Superior
Stebbins, W. W. ---------- St. Petersburg, Florida
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Twohig, D. J. ---------- Fond du Lac
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Washburn, R. G. ---------- Milwaukee
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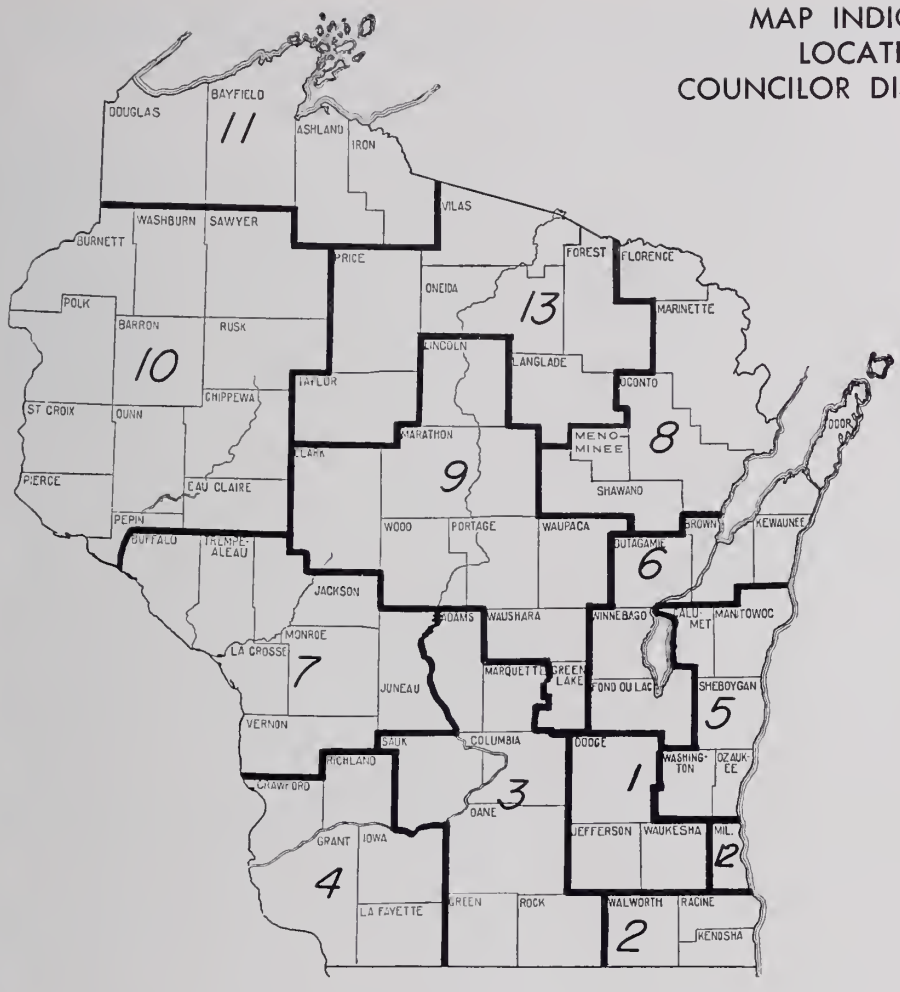
* Granted life membership in 1964.

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



COUNCILORS:

FIRST DISTRICT:
W. D. James, M.D., Oconomowoc

SECOND DISTRICT:
G. J. Schulz, M.D., Union Grove

THIRD DISTRICT:
E. J. Nordby, M.D., Madison
M. D. Davis, M.D., Milton
C. W. Stoops, M.D., Madison

FOURTH DISTRICT:
E. M. Dessloch, M.D., Prairie du Chien

FIFTH DISTRICT:
P. B. Blanchard, M.D., Cedarburg

SIXTH DISTRICT:
H. J. Kief, M.D., Fond du Lac
George Nadeau, M.D., Green Bay

SEVENTH DISTRICT:
J. C. Fox, M.D., La Crosse

EIGHTH DISTRICT:
J. M. Bell, M.D., Marinette

NINTH DISTRICT:
R. W. Mason, M.D., Marshfield

TENTH DISTRICT:
R. C. Frank, M.D., Eau Claire

ELEVENTH DISTRICT:
V. E. Ekblad, M.D., Superior

TWELFTH DISTRICT:
L. J. Van Hecke, M.D., Milwaukee
W. J. Houghton, M.D., Milwaukee
H. J. Lee, M.D., Milwaukee
S. L. Chojnacki, M.D., Milwaukee
S. W. Hollenbeck, M.D., Milwaukee

THIRTEENTH DISTRICT:
Marvin Wright, M.D., Rhinelander

Officers and Councilors 1964-1965

State Medical Society of Wisconsin

OFFICERS OF THE SOCIETY

PRESIDENT_____W. P. Curran, M.D., Antigo
Box 420

PRESIDENT-ELECT_____J. H. Houghton, M.D.
Wisconsin Dells, Box 325

SECRETARY_____Mr. C. H. Crownhart, Madison
330 East Lakeside Street

ASSISTANT SECRETARY__Mr. Roy T. Ragatz, Madison
330 East Lakeside Street

TREASURER_____F. L. Weston, M.D., Madison
1 South Pinckney Street

SPEAKER_____Robert E. Callan, M.D., Milwaukee
1733 West Wisconsin Avenue

VICE-SPEAKER_____G. A. Behnke, M.D., Kaukauna
1015 West Wisconsin Avenue

COUNCILORS

(J. C. Fox, M.D., La Crosse, Chairman)
(J. M. BELL, M.D., Marinette, Vice-chairman)

DISTRICTS*

FIRST: Dodge, Jefferson and Waukesha County Societies. W. D. James, M.D., 340 Summit Avenue, Oconomowoc, 1966.

SECOND: Kenosha, Racine and Walworth County Societies. G. J. Schulz, M.D., 722 16th Avenue, Union Grove, 1966.

THIRD: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. E. J. Nordby, M.D., 2715 Marshall Court, Madison, 1967; M. D. Davis, M.D., 309 College Street, Milton, 1965; C. W. Stoops, M.D., 110 East Main Street, Madison, 1966.

FOURTH: Crawford, Grant, Iowa, Lafayette and Richland County Societies. E. M. Dessloch, M.D., Medical Park, Prairie du Chien, 1967.

FIFTH: Calumet, Manitowoc, Sheboygan, Washington and Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg, 1967.

SIXTH: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. H. J. Kief, M.D., 104 South Main Street, Fond du Lac, 1967; George Nadeau, M.D., 128 East Walnut Street, Green Bay, 1965.

SEVENTH: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse, 1965.

EIGHTH: Marinette–Florence, Oconto, and Shawano County Societies. J. M. Bell, M.D. (Vice-chairman), 516 Houston Street, Marinette, 1965.

NINTH: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. R. W. Mason, M.D., 650 South Central Avenue, Marshfield, 1965.

TENTH: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. R. C. Frank, M.D., 550 North Dewey Street, Eau Claire, 1965.

ELEVENTH: Ashland–Bayfield–Iron and Douglas County Societies. V. E. Ekblad, M.D., 1507 Tower Avenue, Superior, 1966.

TWELFTH: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee, 1966; W. J. Houghton, M.D., 2943 North Oakland Avenue, Milwaukee, 1966; Howard J. Lee, M.D., 425 East Wisconsin Avenue, Milwaukee, 1967; S. L. Chojnacki, M.D., 3122 South Thirteenth Street, Milwaukee 15, 1965; S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee 6, 1965.

THIRTEENTH: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Marvin Wright, M.D., 1020 Kabel Avenue, Rhinelander, 1965.

PAST PRESIDENT_____W. J. Egan, M.D., Milwaukee
720 N. Jefferson Street

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

A. A. Quisling, M. D. (1965) _____Madison
2 West Gorham Street

R. E. Galasinski, M.D. (1965) _____Milwaukee
3333 South 27th Street

John M. Bell, M.D. (1966) _____Marinette
516 Houston Street

E. L. Bernhart, M.D. (1966) _____Milwaukee
2714 West Burleigh Street

Alternates

W. B. Hildebrand, M.D. (1965) _____Menasha
59 Racine Street

George Collentine, Jr., M.D. (1965) ____Milwaukee
2266 North Prospect Avenue

J. C. Fox, M.D. (1966) _____La Crosse
212 South Eleventh Street

C. J. Picard, M.D. (1966) _____Superior
425 Twenty-first Avenue East

* Map indicating location of councilor districts, page 75.
Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

Standing Committees—1964-1965

State Medical Society of Wisconsin

COMMITTEE ON CANCER

(Composed of a member from each Councilor District)

G. A. Smiley, M.D.
Chairman

G. A. Smiley, M.D. (1965) ---------- Delavan
Chairman 107 North Third Street

R. C. Glise, M.D. (1965) ---------- Richland Center
Vice-chairman 890 E. Kinder Street

G. I. Uhrich, M.D. (1965) ---------- La Crosse
212 South Eleventh Street

John K. Scott, M.D. (1967) ---------- Madison
1605 Monroe Street

G. H. Williams, M.D. (1967) ---------- Marshfield
650 South Central Avenue

Ralph C. Frank, M.D. (1965) ---------- Eau Claire
550 North Dewey Street

J. J. Gramling, Jr., M.D. (1965) ---------- Milwaukee
324 East Wisconsin Avenue

J. F. Brown, M.D. (1965) ---------- Rhinelander
1020 Kabel Avenue

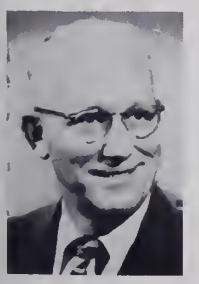
J. R. Hoon, M.D. (1966) ---------- Sheboygan
1011 North 8th Street

William Reed, M.D. (1966) ---------- Watertown
113 North Third

J. E. Dettmann, M.D. (1966) ---------- Green Bay
519 South Monroe

J. G. Telford, M.D. (1966) ---------- Washburn

Vacancy (1967) ---------- Council District 8



COMMITTEE ON GRIEVANCES

E. D. Sorenson, M.D.
Chairman

E. D. Sorenson, M.D. (1965) ---------- Elkhorn
Chairman 104 South Wisconsin Street

J. D. Leahy, M.D. (1966) ---------- Park Falls
Vice-chairman 170 Fourth Avenue North

M. F. Huth, M.D. (1966) ---------- Baraboo
203 Fourth Street

Donald R. Griffith (1966) ---------- Eau Claire
314 Grand Ave. East

C. E. Wall, M.D. (1967) ---------- Manitowoc
904A S. Eighth Street

D. W. Dailey, M.D. (1967) ---------- Elcho

O. G. Moland, M.D. (1967) ---------- Augusta

E. W. Mason, M.D. (1965) ---------- Milwaukee
324 East Wisconsin Avenue

R. W. Mason, M.D. (1965) ---------- Marshfield
650 South Central Avenue

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D.
Chairman

D. E. Dorchester, M.D. (1966) ---------- Sturgeon Bay
Chairman 1715 Rhode Island Street

R. J. Botham, M.D. (1966) ---------- Madison
Vice-chairman 1313 Fish Hatchery Road

J. E. Martin, Jr., M.D. (1966) ---------- Delavan
607 Walworth Avenue

J. S. Devitt, M.D. (1967) ---------- Milwaukee
2243 N. Prospect Avenue

Louis Olsman, M.D. (1967) ---------- Kenosha
625 57th Street

C. A. Olson, M.D. (1967) ---------- Baldwin

C. J. Picard, M.D. (1965) ---------- Superior
425–21st Avenue, East

D. G. MacMillan, M.D. (1965) ---------- Barron
1220 Woodland

W. E. Acheson, M.D. (1965) ---------- Valders
Liberty Street

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D.
Chairman

Robert G. Zach, M.D. (1967) _____ Monroe
Chairman 810–19th Avenue

W. T. Russell, M.D. (1966) _____ Sun Prairie
Vice-chairman 215 East Main Street

R. L. Gilbert, M.D. (1965) _____ La Crosse
1707 Main Street

J. B. Durst, M.D. (1965) _____ La Crosse
1707 Main Street

P. K. Odland, M.D. (1965) _____ Janesville
305 Court Street

J. A. Killins, M.D. (1965) _____ Green Bay
123 North Military Ave.

S. A. Freitag, M.D. (1965) _____ Janesville
500 W. Milwaukee Street

G. O. Stubenrauch, M.D. (1966) _____ Milwaukee
7635 W. Oklahoma Ave.

J. A. Kelble, M.D. (1966) _____ Milwaukee
2243 N. Prospect Ave.

J. L. Teresi, M.D. (1966) _____ Brookfield
14760 Virginia

G. M. Shinners, M.D. (1966) _____ Green Bay
P.O. Box 98

W. W. Moir, M.D. (1966) _____ Sheboygan
Sheboygan Memorial Hospital

K. L. Siebecker, Jr., M.D. (1967) _____ Madison
1300 University Ave.

H. A. Peters, M.D. (1967) _____ Madison
1300 University Ave.

J. V. Bolger, Jr., M.D. (1967) _____ Waukesha
102 E. Main Street

J. S. Veum, M.D. (1967) _____ Appleton
401 N. Oneida Street

J. M. Lubitz, M.D. (1969) _____ Brookfield
1950 Alverno Drive

H. E. Oppert, M.D. (1967) _____ Viroqua
318 South Main Street

Earl C. Quackenbush, M.D. (1967) _____ Hartford
14 North Main Street

C. F. Broderick, M.D. (1968) _____ Wisconsin Dells
Box 325

L. J. Kurten, M.D. (1965) _____ Racine
2405 Northwestern Ave.

President, ex officio
President-elect, ex officio
Secretary, ex officio

COMMISSION ON SCIENTIFIC MEDICINE

P. T. Bland, M.D.
Chairman

P. T. Bland, M.D. (1965) _____ Westby
Chairman 107 North Main Street

J. K. Curtis, M.D. (1967) _____ Madison
2500 Overlook Terrace

G. E. Collentine, Jr., M.D. (1966) _____ Milwaukee
2266 North Prospect Avenue

T. V. Geppert, M.D. (1968) _____ Madison
1313 Fitchburg Road

James Weygandt, M.D. (1965) _____ Sheboygan Falls
716 Monroe Street

Warren Simmons, M.D. (1966) _____ Rhinelander
1020 Kabel Avenue

W. T. Russell, M.D. (1967) _____ Sun Prairie
215 East Main Street

Ovid Meyer, M.D. (1968) _____ Madison
1300 University Avenue

Edgar S. Gordon, M.D. (1969) _____ Madison
1300 University Avenue

Albert Martin, M.D. (1969) _____ Milwaukee
324 E. Wisconsin Avenue

Victor S. Falk, Jr., M.D., Medical Editor, *Wisconsin Medical Journal* _____ Edgerton
Ex officio 5 West Rollin Street

John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine _____ Milwaukee
Ex officio 561 North Fifteenth Street

Vacancy, Dean, University of Wisconsin Medical School _____ Madison
Ex officio

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

G. B. Murphy, Jr., M. D.
Chairman

G. B. Murphy, Jr., M.D. (1967) _____ La Crosse
Chairman 1836 South Avenue

R. P. Fruehauf, M.D. (1967) _____ Superior
1514 Ogden Avenue

G. W. Hilliard, M.D. (1967) _____ Milwaukee
425 West North Avenue

T. H. McDonell, M.D. (1965)_____Waukesha
217 Wisconsin Avenue

S. L. Henke, M.D. (1966)_____Eau Claire
314 Grand Avenue

H. G. Bayley, M.D. (1966)_____Beaver Dam
116 Iroquois Parkway

M. V. Overman, M.D. (1965)_____Neillsville

A. J. Richtsmeier, M.D. (1965)_____Madison
110 East Main Street

P. C. Dietz, M.D. (1966)_____La Crosse
1020 Market Street

John S. Hirschboeck, M.D., Marquette University School of Medicine_____Milwaukee
Ex officio 561 North Fifteenth Street

Vacancy, University of Wisconsin Medical School
Ex officio Madison

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Clinical Medicine
Disaster Medical Care
Commission on Medical Care Plans
Commission on State Departments
Editorial Board
Military Medical Service
Health Economics of American Life (HEAL)
Past Presidents

Medical Bowling Tournament

Sat.–Sun., March 13–14
Marshfield, Wisconsin

- Men's Singles
- Women's Singles
- Men's Doubles
- Women's Doubles
- Mixed Doubles
- Team Events

All will be handicap events—those who do not bowl regularly are urged to bowl six or more games prior to the tournament to establish your handicap.

Dinner and Dancing Saturday Evening

Watch your mail for your Entry Blank!

COMPONENT COUNCIL COMMITTEES 1964–1965

(Appointed by the Chairman of the Council and composed of members of the Council)

EXECUTIVE COMMITTEE

James C. Fox, M.D._____La Crosse
Chairman of the Council
212 South 11th Street

J. M. Bell, M.D._____Marinette
Vice-chairman of the Council
516 Houston Street

Ralph C. Frank, M.D._____Eau Claire
Chairman, Planning
550 North Dewey Street

E. M. Dessloch, M.D.__Prairie du Chien
Chairman, Finance Medical Park

L. J. Van Hecke, M.D.____Milwaukee
Chairman, Scientific Medicine
6001 West Center Street

E. J. Nordby, M.D._____Madison
Chairman, Economic Medicine
2715 Marshall Court

W. P. Curran, M.D., president__Antigo
Ex officio Box 420

J. H. Houghton, M.D., president-elect
_____Wisconsin Dells
Ex officio Box 325

W. J. Egan, M.D., past president
_____Milwaukee
Ex officio 720 North Jefferson

SCIENTIFIC MEDICINE

L. J. Van Hecke, M.D.____Milwaukee
Chairman
6001 West Center Street

H. J. Kief, M.D._____Fond du Lac
104 South Main Street

C. W. Stoops, M.D._____Madison
110 East Main Street

W. J. Houghton, M.D._____Milwaukee
2943 North Oakland Avenue

S. W. Hollenbeck, M.D.____Milwaukee
2650 West Fond du Lac Avenue

James C. Fox, M.D._____La Crosse
Ex officio 212 South 11th Street

ECONOMIC MEDICINE

E. J. Nordby, M.D._____Madison
Chairman
2715 Marshall Court

P. B. Blanchard, M.D._____Cedarburg
204 North Washington Avenue

G. J. Schulz, M.D._____Union Grove
722 15th Avenue

Marvin Wright, M.D.____Rhinelander
1020 Kabel Avenue

George Nadeau, M.D._____Green Bay
128 East Walnut Street

James C. Fox, M.D._____La Crosse
Ex officio 212 South 11th Street

PLANNING

Ralph C. Frank, M.D._____Eau Claire
Chairman
550 North Dewey Street

R. W. Mason, M.D._____Marshfield
650 South Central Avenue

Milton D. Davis, M.D._____Milton
309 College Street

Howard J. Lee, M.D._____Milwaukee
425 East Wisconsin Avenue

H. J. Kief, M.D._____Fond du Lac
104 South Main Street

James C. Fox, M.D._____La Crosse
Ex officio 212 South 11th Street

FINANCE

E. M. Dessloch, M.D. (1966)
_____Prairie du Chien
Chairman Medical Park

E. J. Nordby, M.D. (1966)___Madison
2715 Marshall Court

W. D. James, M.D. (1967)
_____Oconomowoc
340 Summit Avenue

R. C. Frank, M.D. (1967)__Eau Claire
550 North Dewey Street

J. M. Bell, M.D. (1965) ____Marinette
516 Houston Street

S. L. Chojnacki, M.D. (1965)
_____Milwaukee
3122 South 13th Street

F. L. Weston, M.D., treasurer
Ex officio Madison
One South Pinckney Street

OFFICERS OF SCIENTIFIC SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON ANESTHESIOLOGY

President _____ Sherman Myers, Milwaukee
Secretary _____ Sheldon Burchman, Milwaukee
Delegate _____ Harry Thimke, Eau Claire
Alternate _____ David Noll, Madison

SECTION ON DERMATOLOGY

President _____ Richard J. Rowe, Marshfield
Secretary _____ Robert Pittelkow, Milwaukee
Delegate _____ Joel Taxman, Milwaukee
Alternate _____ G. O. Stubenrauch, Milwaukee

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Secretary _____ J. A. Kelble, Milwaukee
Delegate _____ R. R. Richards, Eau Claire
Alternate _____ J. A. Kelble, Milwaukee

SECTION ON INTERNAL MEDICINE

President _____ George Gutmann, Janesville
Secretary _____ John Wishart, Eau Claire
Delegate _____ George Gutmann, Janesville
Alternate _____ John Wishart, Eau Claire

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Secretary _____ C. W. Osgood, Wauwatosa
Delegate _____ R. E. O'Connor, Madison
Alternate _____ Edward Houfek, Sheboygan

SECTION ON OBSTETRICS AND GYNECOLOGY

President _____ Leo Grinney, Racine
Secretary _____ R. E. Whitsitt, Madison
Delegate _____ Donald Price, Madison
Alternate _____ R. E. Whitsitt, Madison

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman _____ Robert Schmidt, Green Bay
Secretary _____ Clemens Kirchgeorg, Neenah
Delegate _____ Frank Treskow, Milwaukee
Alternate _____ John Doolittle, Madison

SECTION ON ORTHOPEDICS

President _____ Herman Wirka, Madison
Secretary _____ Henry J. Okagaki, Madison
Delegate _____ John Van Driest, Sheboygan
Alternate _____ Marvin Olson, Racine

SECTION ON PATHOLOGY

President _____ Robert Haukohl, Milwaukee
Secretary _____ D. J. La Fond, Milwaukee
Delegate _____ J. L. Teresi, Brookfield
Alternate _____ Lars Kleppe, Beloit

SECTION ON PEDIATRICS

Chairman _____ Stewart L. Griggs, Green Bay
Secretary _____ Edward Zupanc, Monroe
Delegate _____ Richard L. Myers, Green Bay
Alternate _____ J. R. Guy, Waukesha

SECTION ON PUBLIC HEALTH

President _____ E. H. Jorris, Madison
Secretary _____ Josef Preizler, Madison
Delegate _____ C. K. Kincaid, Madison
Alternate _____ G. M. Shinners, Green Bay

SECTION ON RADIOLOGY

President _____ T. J. Pfeffer, Milwaukee
Secretary _____ Charles Benkendorf, Green Bay
Delegate _____ Howard Mauthe, Fond du Lac
Alternate _____ Leslie Jones, Racine

SECTION ON SURGERY

President _____ Norman O. Becker, Fond du Lac
Secretary _____ John T. Mendenhall, Madison
Delegate _____ Jack A. Killins, Green Bay
Alternate _____ Albert G. Martin, Milwaukee

SECTION ON UROLOGY

President _____ John J. Mueller, Madison
Secretary _____ Norman B. Hodgson, Milwaukee
Delegate _____ F. M. Hilpert, Racine
Alternate _____ Arthur Jacobsen, Racine

SMS COUNCIL COMMITTEES 1964–1965

(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

DISASTER MEDICAL CARE

J. S. Wier, M.D._____Fond du Lac
Chairman
80 Sheboygan Street

E. A. Bachhuber, M.D.____Milwaukee
561 North 15th Street

S. J. Graiewski, M.D._____Oshkosh
155 North Sawyer

D. L. Williams, M.D._____Madison
30 South Henry Street

Harold Cook, M.D._____Milwaukee
8700 W. Wisconsin Avenue

E. P. Rohde, M.D._____Galesville

EDITORIAL BOARD

D. W. Ovitt, M.D._____Milwaukee
2266 North Prospect Avenue

M. F. Huth, M.D._____Baraboo
203 Fourth Street

L. G. Kindschi, M.D._____Monroe
1770 13th Street

G. A. Cooper, M.D._____Madison
110 E. Main Street

M. C. F. Lindert, M.D._____Milwaukee
6745 West Wells Street

MILITARY MEDICAL SERVICE

F. L. Weston, M.D._____Madison
Chairman
1. So. Pinckney Street

J. M. Sullivan, M.D._____Milwaukee
161 W. Wisconsin Avenue

M. H. Steen, M.D._____Oshkosh
421 Jefferson Street

O. G. Moland, M.D._____Augusta

D. S. Arvold, M.D._____Shawano
117 E. Green Bay Street

HEALTH ECONOMICS OF AMERICAN LIFE (HEAL)

(Congressional District listed at left)

1—G. C. Schulte, M.D._____Kenosha
522 56th Street

L. J. Kurten, M.D._____Racine
2405 Northwestern Avenue

2—R. N. Allin, M.D._____Madison
Chairman
1313 Fish Hatchery Road

3—R. A. Pribek, M.D._____La Crosse
212 South 11th Street

4—Millard Tufts, M.D.____Milwaukee
208 E. Wisconsin Avenue

5—Norbert Enzer, M.D.___Milwaukee
948 No. 12th Street

6—D. J. Twohig, M.D.____Fond du Lac
80 Sheboygan Street

7—Albert M. Kohn, M.D._Stevens Point
313 North Fremont

8—L. H. Edelblute, M.D.__Green Bay
744 S. Webster Ave.

9—C. A. Olson, M.D._____Baldwin

10—M. L. Whalen, M.D._____Bruce
T. J. Doyle, M.D._____Superior
1507 Tower Avenue

Member-at-large:

A. J. McCarey, M.D._____Green Bay
610 Northern Building

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D. (1967)
_____Prairie du Chien
Chairman
Medical Park

G. W. Carlson, M.D. (1967)_Appleton
Suite 604, Zuelke Bldg.

D. N. Goldstein, M.D. (1967)
_____ Kenosha
723 58th Street

A. W. Hilker, M.D. (1967)
_____Eau Claire
314 Grand Avenue East

P. B. Mason, M.D. (1967) _Sheboygan
1011 No. 8th Street

E. J. Nordby, M.D. (1967) __Madison
2715 Marshall Court

L. O. Simenstad, M.D. (1967) Osceola
195 Hammond Street

R. S. Baldwin, M.D. (1966) Marshfield
650 South Central Avenue

A. H. Stahmer, M.D. (1967) _Wausau
120 Clarke Street

Howard Mauthe, M.D. (1967)
_____Fond du Lac
340 Sheboygan Street

W. T. Casper, M.D., (1965)_Milwaukee
5325 W. Burleigh Street

M. D. Davis, M.D. (1965)_____Milton
309 College Street

Robert Krohn, M.D. (1965)
_____Black River Falls
Main Street

A. J. McCarey, M.D. (1965)
_____Green Bay
610 Northern Bldg.

J. T. Sprague, M.D. (1965)__Madison
109 E. Johnson Street

F. H. Wolf, M.D. (1965)__La Crosse
419–421 Main Street

K. H. Doege, M.D. (1966)__Marshfield
650 So. Central Avenue

Milton Finn, M.D. (1966)__Superior
1507 Tower Avenue

Donald A. Jeffries, M.D. (1966)
_____ Shawano
117 E. Green Bay St.

Charles Benkendorf, M.D. (1966)
_____Green Bay
835 S. Van Buren

C. G. Reznichek, M.D. (1966)__Madison
1912 Atwood Ave.

R. M. Moore, M.D. (1966)__Frederic

President Curran

President-elect Houghton

COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., M.D._____Madison
Chairman
16 No. Carroll Street

L. M. Simonson, M.D._____Sheboygan
Vice-chairman
1011 No. 8th Street

Division Chairmen:

J. W. Nellen, M.D._____Green Bay
Handicapped Children
130 E. Walnut Street

A. M. Hutter, M.D._____Fond du Lac
Aging
20 Forest Avenue

John Evrard, M.D._____Milwaukee
Maternal & Child Welfare
208 East Wisconsin Avenue

C. A. Wunsch, M.D. _____Green Bay
Nervous & Mental Diseases
1200 South Quincy

H. W. Carey, M.D._____Lancaster
Public Assistance
257 No. Madison Street

R. B. Windsor, M.D._____Sheboygan
Safe Transportation
1011 N. 8th St.

H. A. Anderson, M.D.__Stevens Point
Chest Diseases

J. C. H. Russell, M.D. __Fort Atkinson
School Health
38 South Water Street

Meyer S. Fox, M.D._____Milwaukee
Visual & Hearing Defects
2040 W. Wisconsin Avenue

Paul Dudenhoefer, M.D.____Milwaukee
Rehabilitation
6541 Washington Circle

COMMITTEE ON CLINICAL MEDICINE

T. J. Greenwalt, M.D._____Milwaukee
Chairman
763 North 18th Street

Karl H. Beck, M.D._____Wauwatosa
949 Glenview Avenue

Maurice Hardgrove, M.D.__Milwaukee
208 E. Wisconsin Avenue

N. A. McGreane, M.D.____Darlington
128 E. Ann Street

Albert W. Bryan, M.D._____Tomah

PAST PRESIDENTS

W. P. Curran. M.D. _____Antigo
Chairman Box 420

W. J. Egan, M.D. _____Milwaukee
720 North Jefferson Street

M. A. McGarty, M.D. _____La Crosse
509 State Bank Building

F. G. Connell, M.D. _____Oshkosh
1217 Washington Avenue

R. P. Sproule, M.D. _____Milwaukee
1024 East State Street

Gunnar Gundersen, M.D. __La Crosse
1836 South Avenue

R. M. Kurten, M.D. _____Racine
3047 Ruby Street

W. D. Stovall, M.D. _____Madison
Two Thorstrand Road

K. H. Doege, M.D. _____Marshfield
650 South Central Avenue

J. C. Griffith, M.D. _____Milwaukee
2243 North Prospect Avenue

H. K. Tenney, M.D. _____Madison
1 South Pinckney Street

A. J. McCarey, M.D. _____Green Bay
610 Northern Building

E. L. Bernhart, M.D. _____Milwaukee
2714 West Burleigh Street

L. O. Simenstad, M.D. _____Osceola
195 Hammond Street

H. E. Kasten, M.D. _____Beloit
419 Pleasant Street

W. B. Hildebrand, M.D. ____Menasha
59 Racine Street

E. D. Sorenson, M.D. _____Elkhorn
104 South Wisconsin Street

L. H. Lokvam, M.D. _____Kenosha
723–58th Street

N. A. Hill, M.D. _____Madison
304 West Washington Avenue

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac ---------- 1841–1847
J. B. Dousman, Milwaukee ---------- 1848, 1849
A. L. Castleman, Delafield ---------- 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield ---------- 1855
John Mitchell, Janesville ---------- 1856
D. Cooper Ayres, Green Bay ---------- 1857
Clark G. Pease, Janesville ---------- 1858, 1859
E. S. Carr, Madison ---------- 1860, 1861
Solomon Blood, Rochester ---------- 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee ---------- 1870
H. P. Strong, Beloit ---------- 1871
John Favill, Madison ---------- 1872
Harmon Van Dusen, Mineral Point ---------- 1873
M. Waterhouse, Portage ---------- 1874
J. T. Reeve, Appleton ---------- 1875
J. B. Whiting, Janesville ---------- 1876
J. K. Bartlett, Milwaukee ---------- 1877
Darius Mason, Prairie du Chien ---------- 1878
Nicholas Senn, Milwaukee ---------- 1879
J. G. Meachem, Sr., Racine ---------- 1880
Ira Manley, Jr., Markesan ---------- 1881
William Meacher, Portage ---------- 1882
T. P. Russell, Oshkosh ---------- 1883
N. M. Dodson, Berlin ---------- 1884
E. W. Bartlett, Milwaukee ---------- 1885
G. M. Steele, Oshkosh ---------- 1886
S. C. Johnson, Hudson ---------- 1887
L. G. Armstrong, Boscobel ---------- 1888
J. R. Barnett, Neenah ---------- 1889
E. M. Rogers, Hartford ---------- 1890
G. D. Ladd, Milwaukee ---------- 1891
G. F. Witter, Grand Rapids, Mich. ---------- 1892
B. T. Phillips, Menominee, Mich. ---------- 1893
B. C. Brett, Green Bay ---------- 1894
Almon Clarke, Sheboygan ---------- 1895
F. W. Epley, New Richmond ---------- 1896
B. O. Reynolds, Lake Geneva ---------- 1897
William Mackie, Milwaukee ---------- 1898
Herman Reineking, Milwaukee ---------- 1899
W. T. Sarles, Sparta ---------- 1900
J. F. Pritchard, Manitowoc ---------- 1901
W. H. Neilson, Milwaukee ---------- 1902
J. V. R. Lyman, Eau Claire ---------- 1903
F. E. Walbridge, Milwaukee ---------- 1904
C. W. Oviatt, Oshkosh ---------- 1905
J. R. Currens, Two Rivers ---------- 1906
L. H. Pelton, Waupaca ---------- 1907
W. E. Ground, Superior ---------- 1908
Gilbert E. Seaman, Madison ---------- 1909
Edward Evans, La Crosse ---------- 1910
Byron M. Caples, Waukesha ---------- 1911
John M. Dodd, Ashland ---------- 1912
Arthur J. Patek, Milwaukee ---------- 1913
Charles S. Sheldon, Madison ---------- 1914
T. J. Redelings, San Diego, Cal. ---------- 1915
L. J. Jermain, Milwaukee ---------- 1916
Hoyt E. Dearholt, Milwaukee ---------- 1917
Gustave Windesheim, Kenosha ---------- 1918
D. J. Hayes, Milwaukee ---------- 1919
C. R. Bardeen, Madison ---------- 1920
H. W. Abraham, Appleton* ---------- 1921
M. A. McGarty, La Crosse ---------- 1921
S. Hall, Ripon ---------- 1922
F. G. Connell, Oshkosh ---------- 1923
Rock Sleyster, Wauwatosa ---------- 1924
Wilson Cunningham, Platteville ---------- 1925
Joseph F. Smith, Wausau ---------- 1926
Arthur W. Rogers, Oconomowoc ---------- 1927
John J. McGovern, Milwaukee ---------- 1928
Karl W. Doege, Marshfield ---------- 1929
F. J. Gaenslen, Milwaukee ---------- 1930
A. J. McDowell, Soldiers Grove** ---------- 1931
C. A. Harper, Madison ---------- 1931
Otho Fiedler, Sheboygan ---------- 1932
Reginald H. Jackson, Madison ---------- 1933
Stanley J. Seeger, Texarkana, Texas ---------- 1934
T. J. O'Leary, Superior ---------- 1935
R. M. Carter, Green Bay ---------- 1936
Stephen E. Gavin, Fond du Lac ---------- 1937
James C. Sargent, Milwaukee ---------- 1938
A. E. Rector, Appleton ---------- 1939
R. G. Arveson, Frederic ---------- 1940
R. P. Sproule, Milwaukee ---------- 1941
Gunnar Gundersen, La Crosse ---------- 1942
F. E. Butler, Menomonie ---------- 1943
R. M. Kurten, Racine ---------- 1944
Charles Fidler, Milwaukee ---------- 1945
P. R. Minahan, Green Bay ---------- 1946
C. A. Dawson, River Falls ---------- 1947
W. D. Stovall, Madison ---------- 1948
K. H. Doege, Marshfield ---------- 1949
J. W. Truitt, Milwaukee ---------- 1950
H. H. Christofferson, Colby ---------- 1951
A. H. Heidner, West Bend ---------- 1952
J. C. Griffith, Milwaukee ---------- 1953
H. Kent Tenney, Madison ---------- 1954
Arthur J. McCarey, Green Bay*** ---------- 1955
Ervin L. Bernhart, Milwaukee ---------- 1956
L. O. Simenstad, Osceola ---------- 1957
Harry E. Kasten, Beloit ---------- 1958
Jerome W. Fons, Milwaukee**** ---------- 1958
W. B. Hildebrand, Menasha ---------- 1960
E. D. Sorenson, Elkhorn ---------- 1961
L. H. Lokvam, Kenosha ---------- 1962
N. A. Hill, Madison ---------- 1963
W. J. Egan, Milwaukee ---------- 1964

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.† ---------- 1930
Cornelius A. Harper, M.D.† ---------- 1930
John J. McGovern, M.D.† ---------- 1931
Louis M. Jermain, M.D.† ---------- 1931
Edward Evans, M.D.† ---------- 1931
Mina B. Glasier, M.D.† ---------- 1932
Arthur W. Rogers, M.D.† ---------- 1934
Rock Sleyster, M.D.† ---------- 1934
Olin West, M.D.† ---------- 1934
Edward A. Birge, Ph.D.† ---------- 1935
Arthur J. Patek, M.D.† ---------- 1935
Joseph F. Smith, M.D.† ---------- 1937
Eben J. Carey, M.D.† ---------- 1938
William S. Middleton, M.D. ---------- 1938
Fred G. Johnson, M.D.† ---------- 1939
William D. Stovall, M.D. ---------- 1940
Ludvig Hektoen, M.D.*† ---------- 1941
Stephen E. Gavin, M.D.† ---------- 1944
F. Gregory Connell, M.D. ---------- 1947
E. R. Schmidt, M.D.† ---------- 1949
Armand J. Quick, M.D. ---------- 1950
F. A. Stratton, M.D.† ---------- 1951
Gunnar Gundersen, M.D. ---------- 1953
W. J. Meek, Ph.D.† ---------- 1953
R. G. Arveson, M.D.† ---------- 1957
Edwin B. Fred, Ph.D. ---------- 1958
Harry Beckman, M.D. ---------- 1959
Elizabeth Comstock, M.D. ---------- 1961
Harry Steenbock, Ph.D. ---------- 1963
Francis J. L. Blasingame, M.D. ---------- 1964

* Centennial Award. † Deceased.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a nonphysician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission ---------- 1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library) ---------- 1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) ---------- 1963

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Street, Milwaukee 2.

Catholic Charities Bureau, 1209 Hughitt Ave., Superior.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 13.

Lutheran Welfare Service of Wisconsin and Upper Michigan, 3126 West Highland Boulevard, Milwaukee.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 385, State Office Bldg., Madison 2.

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee, 53205.

LICENSED MATERNITY HOMES:

Infant of Prague Maternity Home (Catholic), 304 Front Street East, Ashland.

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Rosalie Hall Maternity Home (Catholic), 1233 North 23rd Street, Milwaukee.

St. Francis Maternity Residence (Catholic), 11th and Market Streets, La Crosse.

Marian Hall (Catholic), 1725 Dousman Street, Green Bay

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

Officers of State Boards and Commissions

Wisconsin State Board of Health

MEMBERS OF THE BOARD

William T. Clark, M.D. (1963) — Janesville
President

Edward N. Vig, M.D. (1966) — Viroqua
Vice-president

Elizabeth Baldwin, M.D. (1964) — Marshfield
James F. Crow, Ph.D. (1965) — Madison
Jacob E. Kaufman, M.D. (1967) — Green Bay
Irving J. Ansfield, D.O. (1968) — Milwaukee
Harold A. Bachhuber, M.D. (1969) — Sauk City

EXECUTIVE OFFICERS

State Health Officer — Carl N. Neupert, M.D., M. S. P. H.
Assistant State Health Officer — E. H. Jorris, M.D., M. S. P. H.

GENERAL ADMINISTRATION

E. H. Jorris, M.D., M. S. P. H. — Director

BUREAU, DIVISION OR UNIT	ADMINISTRATIVE HEAD	TITLE
Division of Civil Defense	Louis E. Remily, M.P.H.	Director
Division of Research	Vacancy	Director
Division of Business Management	Arthur E. Yuds, B.B.A.	Director
Division of Internal Services	Lenore Brandon	Supervisor
Division of Fiscal Services	Glenn B. Fischer, B.B.A.	Director
Division of Personnel	Richard J. Siesen, B. S.	Director
Division of Funeral Directing & Embalming	Helen Kjelson	Supervisor
Division of Cosmetology	Kathleen Bower	Supervisor
Division of Barbering	Thomas D. Ritchie	Supervisor

GENERAL SERVICES

E. H. Jorris, M.D., M. S. P. H. — Director

Division of Professional Training	Vacancy	Director
Bureau of Vital Statistics	L. E. Aase, B. S., M. P. H.	Director
Statistical Services	Raymond D. Nashold, M. S.	Director
Microfilm Laboratory	Duane A. Hambrecht	Supervisor
Division of Hospital and Related Services	Vincent F. Otis	Director
Division of Public Health Nursing	Ione M. Rowley, R. N., B. S.	Director

PREVENTABLE DISEASES

Vacancy — Director
Vacancy — Assistant Director

Division of Heart Disease Control	Vacancy	Director
Division of Chronic Disease and Aging	Paul F. Fleer, M.Ed.	Administrator
Bureau of Communicable Diseases	Josef Preizler, M.D., M. P. H.	Director
Division of Tuberculosis Control	Josef Preizler, M.D., M. P. H.	Director
Division of Mobile Unit Case Finding	Josef Preizler, M.D., M. P. H.	Director
Division of Venereal Disease Control	A. L. Van Duser, M.D., M. P. H.	Director
Division of Cancer Control	A. L. Van Duser, M.D., M. P. H.	Director
Division of Laboratory Evaluation	A. L. Van Duser, M.D., M. P. H.	Director

SANITARY ENGINEERING

O. J. Muegge, M. S., State Sanitary Engineer — Director
Harvey E. Wirth, M. S. — Assistant Director

Division of Public Water Supplies	Ceaser A. Stravinski, M. S.	Director
Division of Public Sewerage	Leonard A. Montie, M. S.	Director

(Continued on next page)

STATE BOARD OF HEALTH *(continued)*

Division of Well Drilling and Sanitation Services	Thomas A. Calabresa, M. S.	Director
Milk Certification	Clarence K. Luchterhand	Supervisor
Division of Occupational Health	William L. Lea, Ph. D.	Director
Division of Radiation Protection	William L. Lea, Ph. D.	Director
Division of Air Pollution Control	Vacancy	Director
Division of Plumbing	William R. Koenig	Director
Division of Hotels and Restaurants	Roy K. Clary, B. S.	Director
Division of Water Pollution	Theodore F. Wisniewski, B. S.	Director

COMMUNITY HEALTH SERVICES

James L. Wardlaw, Jr., M.D., M. P. H. — Director
Vacancy — Assistant Director

Bureau of Maternal and Child Health	Vacancy	Director
Division of Dental Health	Michael C. Arra, D. D. S., M. P. H.	Director
Division of Health Education	Luida E. Sanders, M. A., M. P. H.	Director
Division of School Health	Oscar R. Cade, M. S. P. H.	Director
Division of Nutrition	Lucile K. Billington, M. S.	Director
Division of Child Behavior and Development	A. B. Abramovitz, M. A.	Director

DISTRICT HEALTH OFFICES

No. 1—Room 160, Hill Farms State Office Building, 4802 Sheboygan Avenue; Phone 266–2245 — Madison
No. 2—Milwaukee State Office Building, 819 N. 6th Street; Phone 224–4486 — Milwaukee
No. 3—146 Forest Avenue; Phone 922–1290 — Fond du Lac
No. 4—District State Office Building, 250 Mormon Coulee Road; Phone 4–8289 — La Crosse
No. 5—District State Office Building, 1681 Second Avenue South; P. O. Box 270; Phone 423–4730 — Wisconsin Rapids
No. 6—Room 612, City Hall, 100 North Jefferson Street; P. O. Box 98; Phone 437–8727 — Green Bay
No. 7—Eau Claire State Office Building, 718 West Clairemont Avenue; Phone 834–2931 — Eau Claire
No. 8—1009 Lincoln Street; P. O. Box 249; Phone 362–2308 — Rhinelander

Wisconsin State Board of Public Welfare

MEMBERS OF THE BOARD

W. D. Stovall, M. D. (1967) — Madison
Chairman
William H. Studley, M.D. (1965) — Milwaukee
Vice-chairman
Mr. Leo Jelinske (1967) — Shawano
Secretary
Mr. Ralph Uihlein (1963) — Milwaukee
Mrs. Joseph Melli (1969) — Madison
Mrs. Wallace Lomoe (1965) — Milwaukee
Mr. Wilbert Walter (1967) — Milwaukee
Mr. Albert M. Davis (1969) — Milwaukee
Father Lambert D. Scanlan (1965) — New Holstein

EXECUTIVE STAFF

Director — Mr. Wilbur J. Schmidt
Deputy Director — Mr. George M. Keith

Division of Corrections	Mr. Sanger B. Powers	Director
Division of Mental Hygiene	Leonard J. Ganser, M.D.	Director
Division of Public Assistance	Mr. Thomas J. Lucas, Sr.	Director
Division of Business Management	Mr. Kurt J. Kaspar	Director
Division for Children and Youth	Mr. Frank Newgent	Director

Madison

Basic Science Examiners

John W. Saunders, Ph.D. (1965), *President* — Marquette University Biology Department, Milwaukee
B. H. Kettelkamp, Ph.D. (1967), *Secretary* — Wisconsin State College, 429 Crescent Street, River Falls
Vacancy

Wisconsin State Board of Vocational and Adult Education

MADISON, WISCONSIN 53703
C. L. GREIBER, STATE DIRECTOR

MEMBERS OF THE BOARD

E. J. Fransway (1969), *President*	Employee Member	Milwaukee
Leo Rodems (1965), *Vice-president*	Employer Member	Baraboo
A. E. Mueller (1967)	Employer Member	Madison
Harvey J. Kitzman (1965)	Employee Member	Milwaukee
Richard Lesko (1965)	Employee Member	Kenosha
Arthur Hitt (1967)	Farmer Member	Alma
Philip E. Lerman (1969)	Employer Member	Milwaukee
Kermit Veum (1969)	Farmer Member	Westby
Martin Gunnulson (1967)	Farmer Member	Cambridge
Angus B. Rothwell (ex officio) Supt. Public Instruction		Madison
Mathias Schimenz (ex officio) Chairman, Industrial Commission		Madison

VOCATIONAL REHABILITATION DIVISION

STATE OFFICE: 1 West Wilson Street, Room 830, Madison 53702, Telephone: 266–1281

Adrian E. Towne, Assistant Director for Vocational Rehabilitation, Telephone 266–3017

Mrs. Inez F. Belyea, Medical Social Consultant
John H. Biddick, Senior Supervisor
Melvin J. Chada, Senior Supervisor
John H. Dunn, Public Information Officer
Edward J. Pfeifer, Psychologist
Otto H. Richter, Senior Supervisor
Ray Wilcox, Senior Supervisor

OASI DISABILITY DETERMINATION SECTION: 117 ½ Monona Ave., Madison 53702, Telephone 266–1565

Alfred R. Meier, Senior Supervisor

NO. 1 DISTRICT OFFICE: 1 West Wilson Street, Room 830, Madison 53702, Telephone 266–3656

District Supervisor position vacant

MENDOTA STATE HOSPITAL, 301 Troy Drive, Madison 53704, Telephone 244–8666
Harold Henningsen, Rehabilitation Counselor

LOCAL OFFICE: State Office Building, Mormon Coulee Road, La Crosse 54602, Telephone 4–0474
Carl J. Haase, Rehabilitation Supervisor

NO. 2 DISTRICT OFFICE: 819 North 6th Street, Room 663, Milwaukee 53203, Telephone 224–4677

Kenneth M. Kassner, District Supervisor

MILWAUKEE COUNTY HOSPITAL FOR MENTAL DISEASES, 9035 Watertown Plank Road, Milwaukee, Telephone 258–2040, ext. 3161
Kenneth F. Krumnow, Rehabilitation Counselor

NO. 3 DISTRICT OFFICE: 100 North Jefferson Street, Room 610, Green Bay, Telephone 432–8691

Levern J. Schultz, District Supervisor

WINNEBAGO STATE HOSPITAL, Box H, Winnebago, Telephone 235–4910
Leslie A. Wildes, Rehabilitation Counselor

LOCAL OFFICE: 210 Sixth Street, Wausau 54402, Telephone 848–0276
Roy C. Huser, Rehabilitation Supervisor

LOCAL OFFICE: 408 Empire Building, 20 Forest Avenue, Fond du Lac telephone
Kenneth T. McClarnon, Rehabilitation Supervisor

NO. 4 DISTRICT OFFICE: 718 West Clairemont Avenue, Room 121, Eau Claire, Telephone 835–8615

Laurence E. Opheim—District Supervisor

LOCAL OFFICE: 917 Tower Avenue, Room 11, Superior, Telephone 394–4160
LeRoy R. Forslund, Rehabilitation Supervisor

NO. 5 DISTRICT OFFICE: 312 Seventh Street, Racine, Telephone 632–4477

Roger Siegworth, District Supervisor

LOCAL OFFICE:
Edward C. Wilber, Rehabilitation Supervisor

WOOD COUNTY SPECIAL DEMONSTRATION PROJECT: Court House, Wisconsin Rapids, Telephone 424–1100

A. W. Bouffard—Project Supervisor

LOCAL OFFICE: 116 West Second Street, Marshfield, Telephone 384–4310
Charles J. Jacobson—Rehabilitation Counselor

Wisconsin State Board of Pharmacy

MEMBERS OF THE BOARD

Peter J. Hauper, R. Ph. (1965) ——Union Grove
President
James J. Schutkin, R.Ph. (1966) ——Milwaukee
Joseph T. Hannon, R.Ph. (1967) ——Stevens Point
John R. Hall, R.Ph. (1968) ——Janesville
Arthur C. Moin, R.Ph. (1969) ——Superior

Executive Staff

Paul A. Pumpian, L.L.B., R.Ph., Milwaukee —— *Secretary*
V. V. Appleton, Milwaukee —— *Administrative Assistant*

Wisconsin Industrial Commission

MEMBERS OF THE COMMISSION

Mathias F. Schimenz (1965), Chairman ..... Madison
George W. Otto (1969) ..... Madison
Carl E. Lauri (1967) ..... Madison
Stephen J. Reilly, Administrative Officer–Secretary ..... Madison

Workmen's Compensation Division	Mr. R. E. Gintz	Director
Unemployment Compensation Division	Mr. Paul R. Raushenbush	Director
Industrial Safety and Building Division	Mr. Roger Ostrem	Director
Division of Labor Standards	Mr. Douglas Ajer	Director
Fair Employment Practices Division	Miss Virginia Huebner	Director
Employment Service Division	Mr. Francis J. Walsh	Director
Apprenticeship Division	Mr. Charles Nye	Director
Statistical Division	Mr. Henry Gmeinder	Director

Wisconsin State Board of Medical Examiners

Thomas E. Henney, M.D. (1967) *President* ..... 310 West Conant Street, Portage
Michael L. Sanfelippo, D.O. (1965), *Vice-president* ..... 2219 East Capitol Drive, Milwaukee
Irvin L. Slotnik, M.D. (1967) *Secretary* ..... 950 North 35th Street, Milwaukee
William C. Henske, M.D. (1965) ..... 1st National Bank Building, Chippewa Falls
Richard J. Rogers, M.D. (1965) ..... 11½ North Wisconsin Street, Elkhorn
David A. Werner, M.D. (1965) ..... 1424 Union Avenue, Sheboygan
Ben R. Lawton, M.D. (1967) ..... 650 South Central Avenue, Marshfield
Matthew A. McGarty, M.D. (1967) ..... 509 State Bank Building, La Crosse

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Thomas W. Tormey, Jr., M.D. *Executive Secretary* ..... 1414 South Park Street, Madison

Wisconsin State Board of Nursing

MEMBERS OF THE BOARD

Ione M. Rowley (1967) ..... Madison
President
Frances M. Avery (1967) ..... Milwaukee
Vice-president
Adele G. Stahl, *Secretary* ..... Madison
Monsignor E. J. Goebel (1967) ..... Milwaukee
Carl N. Neupert, M. D. ..... Madison
Betty Callow (1967) ..... Wausau
Daniel E. Dorchester, M.D. (1967) ..... Sturgeon Bay
Anne M. Geyer (1967) ..... Madison
Edward J. Logan (1967) ..... Milwaukee
Frances J. Raettig (1967) ..... Burlington

Executive Staff

Adele G. Stahl ..... Director of Nursing Education
Josephine Balaty ..... Assistant Director of Nursing Education

Department of Nurses, Hill Farms State Office Building, Unit B, 4802 Sheboygan Avenue, Madison 53702 Phone: 266–3735 or 266–3736

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1963.

Minutes of Council Meeting

MADISON, OCTOBER 9, 1964

1. Call to Order and Roll Call

The meeting was called to order by Vice-Chairman Bell at 8:00 p.m. Friday, October 9, 1964, at Society headquarters in Madison. All voting members of the Council were present except Doctors Fox, Mason, Ekblad, and Lee. Others present were President-elect Houghton, Vice-Speaker Behnke; Doctors Bernhart and Galasinski, AMA Delegates, and Picard, alternate; Doctor Simenstad, AMA Trustee; Doctors Nereim and Russell, reference committee chairmen, and Doctor Twohig; Messrs. Murphy, Kluwin, Tiffany, Gill and White, consultants; Messrs. Crownhart, Ragatz, Hansen, Reynolds, Salt and Maroney; Mmes. May and Anderson; Misses Cowan and Pyre.

Doctor Bell announced that Todd Koenig, the young son of Ray Koenig, had only that morning been a victim of drowning, and on motion of Doctor Nordby, severally seconded, the Council asked that an expression of sympathy be sent to Mr. and Mrs. Koenig in behalf of the Council, and this be recorded in its proceedings.

2. Approval of Minutes

On motion of Doctors Kief-Chojnacki, carried, minutes of the August 1964 meeting were approved as distributed.

3. Report of Planning Committee

Doctor Frank presented a proposed report to the House of Delegates on the subject of osteopathy, as reviewed and approved by the Planning Committee that afternoon.

On motion of Doctors Blanchard-Kief, carried, the report was forwarded to the House with the Council's recommendation. (See House Proceedings, 1964 Interim Session, Part B of Supplementary Report of the Council.)

4. Invitational Conference on the Costs of Health Care

Reported to the Council primarily for information were the program and scheduled participants in this conference to be held at the Wisconsin Center on November 9 and 10, sponsored by the University of Wisconsin Medical Center.

5. Future Meeting with Officers of the Auxiliary

On motion of Doctors James-Chojnacki, carried, the Council approved the suggestion that the Secretary make arrangements for officers of the Auxiliary to meet with the Council, at the next or succeeding meeting, for the purpose of expressing appreciation for its assistance, establishing more effective liaison, and discussing Auxiliary problems and projects.

6. Report of Legal Counsel

Mr. Murphy presented a report prepared jointly with Mr. White, certified public accountant, giving a chronological summary of developments to date with reference to the proposal of the district office of IRS that net income of WPS for the year 1961 be taxed on the basis that its operation is not substantially related to the purpose of the State Medical Society. They expected that it might be three years or longer before the matter is finally resolved with the U. S. Treasury.

7. Resolution 12—1964 Interim Session

The resolution offered by the Dane County Medical Society was reviewed by the Council in light of the statement made by it in 1954 relative to the qualifications of a Dean of the University of Wisconsin Medical School then under selection.

Doctor Nordby suggested a restatement of the resolution incorporating reference to the long interest of the Society in the matter, and on motion of Doctors James-Frank, carried, the substitute resolution was adopted and transmitted to the House for consideration. (See House Proceedings, Part A of the Supplementary Report of the Council.)

8. Proposed Meeting with Chairmen of Committees and Commissions

The Council discussed the proposal that a mechanism be established for chairmen of the numerous committees of the Society to meet with the Council to improve communications, develop better liaison and more direct knowledge of various projects.

On motion of Doctors Nadeau-Chojnacki, carried, this was referred to the Planning Committee for a specific recommendation to the Council.

9. Policy Statement on Closed Chest Cardiac Resuscitation

The Wisconsin Nurses Association had inquired whether it was acceptable to the Society that the former proceed with publication of the joint policy statement to various groups under the names of both organizations.

On motion of Doctors Nordby-Kief, carried, the Council agreed to its dissemination by the Wisconsin Nurses Association as suggested.

10. Report on Field Service

By Resolution 2 of May 1964, the Council was requested to report at the interim session of the House on activities and costs of the field service division.

On motion of Doctors Nordby-Frank, carried, the Council approved and forwarded to the House a report prepared by the division director and reviewed by the Finance Committee. (See House Proceedings, Part C of the Supplementary Report of the Council.)

11. 125th Anniversary Year

On motion of Doctor Chojnacki, seconded and carried, the Council forwarded to the House the report and recommendations of the committee of Past Presidents for commemorating 1966. (See House Proceedings, Part D of the Supplementary Report of the Council.)

12. 1965 Budget

The Finance Committee had submitted to the Council a proposed budget for 1965, requested by House action to enable it to determine dues for the ensuing year at the interim session. Doctor Dessloch

pointed out that it was a deficit budget on the basis of current dues, and reported the committee's recommendation that regular dues be increased $10 to permit continuation of projects and services, and that an additional $5 be added to the dues for allocation to the CES Foundation.

On motion of Doctors Nordby-Kief, carried, the budget and recommendation were accepted for transmittal to the House. Doctor Egan asked to be recorded as voting "no" in the belief that the report was incomplete as requested by the House. (See House Proceedings, Part E of the Supplementary Report of the Council.)

13. Resolution of Milwaukee County Medical Society

Doctor Van Hecke requested favorable action by the Council to forward to the House a resolution concerning qualifications for membership on the State Board of Medical Examiners.

On motion of Doctors Dessloch-Nordby, carried, the resolution was forwarded to the House with the recommendation that it be referred to the Commission on Public Policy for study and report back to the Council. (See House Proceedings, Part F of the Supplementary Report of the Council.)

14. Council Committee on Scientific Medicine

Doctor Van Hecke reported that the committee had met that afternoon to review a proposed statement of policy by the Commission on Scientific Medicine on support by and use of the seal of the State Medical Society or its affiliate, the CES Foundation, in reference to educational programs of agencies or groups other than the Society or the Foundation. The committee recommended adoption of the statement with modifications.

On motion of Doctors Van Hecke-Houghton, carried, the statement was approved as follows:

Prior to World War II most postgraduate scientific medical education was a product of medical schools, the American Medical Association, or affiliate state medical societies. With the advent of voluntary health agencies and the establishment of educational foundations by clinic groups the field of postgraduate medical education was broadened appreciably.

In light of this changed "atmosphere" of postgraduate medical education it seems appropriate to enunciate some basic principles and policies in reference to financial support and the use of the seal of the State Medical Society of Wisconsin or the CES Foundation, particularly when support or the use of the seal or logotypes is sought by an agency or group of individuals in publicizing and promoting physician attendance at a postgraduate medical educational program.

The Commission on Scientific Medicine is charged in the Constitution of the State Medical Society of Wisconsin to ". . . study the field of postgraduate education, making available, so far as it lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible."

It has been the understanding of the Commission that it is advisory to the Council and the CES Foundation in all matters pertaining to postgraduate scientific medical education, and for that reason it feels it desirable to express recommendations on the matter of financial support and the use of the Society and CES seals or logotypes on programs which are not directly associated with the State Medical Society of Wisconsin or the CES Foundation.

It is the recommendation of the Commission that encouragement should be given any legitimate teaching program which is designed to improve the scientific knowledge of Society members. This would apply to any teaching programs of our two University Medical Schools, recognized voluntary health agencies, state agencies offering instruction to physicians, and other programs which are ethically conducted and offer instruction by physicians of recognized professional standing. Such encouragement should extend to announcements in the WISCONSIN MEDICAL JOURNAL, by way of printing program summaries, and acceptance of paid advertising of such teaching courses. It should also be limited to "labor charge" cost for the single addressing of announcements to members. An exception is granted to Medical Schools in the State of Wisconsin which shall have these services without charge.

In cases where any agency, foundation, group or individual physician (except the SMS itself, or the CES Foundation) wishes cooperation in addition to that indicated above, particularly if the desire is to use the words "Approved by the State Medical Society of Wisconsin" (or any committee, division or commission of the Society), the following matters of policy would apply:

1. Use of Seal (either the State Medical Society seal or logotype of the CES Foundation): No use of either seal or logotype on the program, announcements, or stationery used in promotion of the teaching program would be allowed.
2. Program Review: Any program using the words "Approved by the State Medical Society of Wisconsin" (or any committee, division or commission of the Society) would have to be approved in toto by the Commission on Scientific Medicine, or its designated representative, before a notation of approval could be used on publicity associated with the meeting.
3. Speaker Furnished: If a speaker is to be furnished as part of the teaching program, these qualifications shall apply:
   a. Credit: The program shall carry a credit line under the name of the speaker, to read: "Lecture sponsored by the State Medical Society of Wisconsin, or the CES Foundation, Inc. of the State Medical Society of Wisconsin."
   b. Reimbursement: Speaker reimbursement shall follow the current schedule associated with the Annual Meeting.
4. Staff Time: Staff time of State Medical Society of Wisconsin employees shall be determined by the Secretary of the State Medical Society of Wisconsin.

15. Adjournment

The meeting adjourned at 10:50 p.m.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

DETAILS ON PHOTOGRAPHY CONTEST AND BOWLING TOURNAMENT

Pages 79 and 34*

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of the State Medical Society of Wisconsin

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W. P. CURRAN, M.D.
Antigo, Wisconsin

A Good Deed Done

■ IT WAS HEART warming to me to see the response of the physicians of Wisconsin to my plea for help for the Wisconsin physician and his family referred to in the letter you all received just prior to Christmas. More than 400 contributions were made in amounts varying from $5.00 to one of $500. Though the amount fell short of what was needed, it gave us a chance to make the world seem a better place in which to live for this unfortunate family, especially at Christmas. A great deal of help, other than actual dollars, is being given these people by physicians and other organizations, and matters are shaping up much better for them.

Several of the letters I received with donations deeply disturb me. We are unaware of the many physicians in Wisconsin and, I presume, throughout the nation, who are having financial difficulties due to age, loss of practice as a result of infirmities, and failure of financial programs set up in the past to do what the individuals thought they would, when they became older. Many physicians wrote of the hardship entailed by the donations they made, citing the fact that it was a struggle for them to continue paying Society dues, increased taxes, and the like, and saying that they would appreciate having some thought given to them, financially.

I suggest that all county medical societies survey their local problems in this regard and give what help is needed in such situations.

Thank you again for your response to a physician in need. I know all who helped felt much better at Christmas. The saying, "It is better to give than to receive," is no fallacy.

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Published Monthly
JANUARY 1965
Vol. 64 No. 1

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Meaningful Tribute

■ ACCORDING TO AN OLD folk-saying, a man is never very far from charity: he is either giving it or receiving it. And in our affluent society with its institutionalized social services and its tax-deductible contributions, there is no scarcity of worthy causes to which a well intentioned doctor can send his money to satisfy his charitable impulses.

One of the most deserving of such causes is the State Medical Society of Wisconsin's Charitable, Educational and Scientific Foundation. Established, administered and disbursed by the SMS, it is in a very real sense a mutual fund in support of state-wide scientific endeavor. Its money is available to help finance a large variety of individuals, institutions and medical projects in Wisconsin. Some of the results achieved with its help have been of universal significance. Contributions to it by doctors who have been professionally trained in or by the state can be considered a token of repayment of the tremendous obligation we owe for that training.

Contributions to the Foundation are convenient to make. Every member of the State Medical Society has been sent a booklet of contribution forms to be used to pay tribute to colleagues, friends or relatives. Instead of sending flowers or making other meaningless gestures in memory of the departed, it is suggested that a contribution be made to the Charitable, Educational and Scientific Foundation. Simply complete the form, hopefully always present on the doctors' desk, and mail it to the CES Foundation with a check. An appropriate notification will be sent to the family in whose honor the contribution is made (with no mention of the amount) and an ackowledgment will be returned to the donor. The matter is handled with dignity and beauty, and the paying of the tribute is endowed with a sense of merit commensurate with the importance of the gesture.

But what is most significant is that the tribute to the memory of the departed is not empty or vain. The money devoted by the donor is put to lasting good work, and the benefit is spread over the entire community.

The permanent memorial is a memorial of living faith in the welfare of our society. A contribution to the CES Foundation is indeed an act facing to the future, and as such it would be impossible to find a more fitting tribute for a Wisconsin doctor to make to honor the memory of the respected deceased. —D.N.G.

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FEBRUARY 1965

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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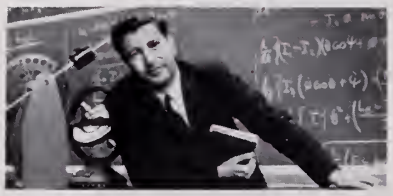

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1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

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PRELIMINARY PROGRAM

1965 Annual Meeting

State Medical Society of Wisconsin

MILWAUKEE—MAY 4, 5, 6

Collentine

DEAR DOCTOR:

The Commission on Scientific Medicine is pleased to direct your attention to the Preliminary Program of the 1965 Annual Meeting, as completed by February 1.

The latter part of March you will receive a special folder, outlining the various noon scientific luncheons. **As attendance is limited, we suggest you make reservations for these as soon as possible after the folder has reached your desk.**

We are particularly happy to announce a special feature of the meeting, on Thursday, May 6. This will be a series of papers by Residents, as noted in the program, and the two best presentations will be given a cash award of $100, with one winning lecture associated with the name of William S. Middleton, M.D., and the second associated with the name of Harry Beckman, M.D.

Attention is also directed to the new character of the Annual Dinner. While not a direct responsibility of the Commission on Scientific Medicine, we are pleased to note that President Curran has designated this as "an evening of fun and fellowship." We feel sure many physicians and their wives will be pleased with the social atmosphere of the Annual Dinner this year.

We urge you to set aside the dates of May 4, 5, and 6 so you can attend at least a portion of the Annual Meeting program. By working closely with the specialty societies and the Wisconsin Academy of General Practice, we have developed a program of quality and diversity. **You can help it succeed by your attendance!**

Sincerely,

P. T. BLAND, M.D.
Chairman, Commission
on Scientific Medicine

GEORGE COLLENTINE, M.D.
Program Chairman

RELATED ACTIVITIES

- HOUSE OF DELEGATES SESSIONS
- PRESIDENT'S RECEPTION AND ANNUAL DINNER
- PAST PRESIDENTS' LUNCHEON
- MEDICAL SCHOOL ALUMNI LUNCHEONS
- SPECIALTY SOCIETY FUNCTIONS
- MEDICAL ART SALON
- PHYSICIANS' PHOTOGRAPHY EXHIBIT

Full details will be included in the complete program to appear in the March issue.

TUESDAY, MAY 4

SPECIAL PROGRAMS ARRANGED IN COOPERATION WITH:

Wisconsin Society of Internal Medicine
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Pathologists
Wisconsin Radiological Society

8:30—REGISTRATION AND TIME TO VIEW EXHIBITS

INTERNAL MEDICINE

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Special Program on "Coronary Angiography"

Moderator: GEORGE E. GUTMANN, M.D., Janesville, President, Wisconsin Society of Internal Medicine

10:00—CORONARY ANGIOGRAPHY AND EXERCISE TOLERANCE

Albert A. Kattus, Jr., M.D., Los Angeles

Professor of Medicine and Chief of the Cardiovascular Division, University of California School of Medicine

10:45—HEMADYNAMIC EFFECTS OF CARDIOVERSION

Robert Corliss, M.D., Madison

Instructor in Medicine, University of Wisconsin Medical School

11:00—RECESS TO VIEW EXHIBITS

11:30—DISCUSSION AND QUESTIONS

Moderator: ROBERT CORLISS, M.D., Madison

Richard Wasserburger, M.D., Madison
Dean Emanuel, M.D., Marshfield
Albert A. Kattus, Jr., M.D., Los Angeles

NOTE: Special luncheon with Doctor Kattus as speaker. Notice on this will reach members late in March.

(Afternoon Session)

2:00—Seminar on "Diagnosis and Therapy of Pulmonary Embolism, Value of Pulmonary Arteriography, Pulmonary Scans, and the Place for Surgery"

Moderator: DEAN EMANUEL, M.D., Marshfield

2:00—MEDICAL DIAGNOSTIC ASPECTS

Dean Emanuel, M.D., Marshfield

2:15—PULMONARY SCANS

Robert C. Meade, M.D., Wood

Veterans Administration Medical Center

2:30—RADIOLOGIC ASPECTS

Thomas Olsen, M.D., Marshfield

2:45—SURGICAL ASPECTS

Richard Sautter, M.D., Marshfield

3:00—RECESS TO VIEW EXHIBITS

3:45—QUESTIONS AND ANSWERS

Doctors Emanuel, Meade, Olsen, and Sautter

OBSTETRICS AND GYNECOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: LEO GRINNEY, M.D., Racine
President, Wisconsin Society of Obstetrics and Gynecology

2:00—PREMATURE RUPTURE OF THE FETAL MEMBRANES

Keith P. Russell, M.D., Los Angeles

Associate Clinical Professor of Obstetrics and Gynecology, University of California School of Medicine

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—ANEMIAS IN PREGNANCY (title tentative)

Roy Holly, M.D., Philadelphia

Professor and Chairman of the Department of Obstetrics and Gynecology, Jefferson Medical College, Pa.

NOTE: Noon luncheons will be arranged with both Doctors Russell and Holly as speakers. Notice on these will reach members in late March.

PATHOLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: EDWIN L. BEMIS, M.D., Milwaukee
Program Chairman, Wisconsin Society of Pathologists

2:00—THE VALUE OF SERUM ENZYME DETERMINATIONS IN CLINICAL DIAGNOSIS

Conrad A. Elvehjem Memorial Lecture

John B. Henry, M.D., Syracuse

Professor and Chairman of the Department of Clinical Pathology, Upstate Medical Center, New York

2:30—SERUM ENZYME ALTERATIONS IN MYOCARDIAL INFARCTION

David J. LaFond, M.D., Milwaukee

2:50—SERUM ENZYME ALTERATIONS IN HEPATOBILIARY DISEASE

Raymond Voet, M.D., Milwaukee

TUESDAY *continued*

3:10—RECESS TO VIEW EXHIBITS

3:45—PANEL DISCUSSION AND QUESTIONS

Doctors Henry, La Fond, and Voet

NOTE: A noon luncheon will be arranged with Doctor Henry as speaker. Notice on this will reach members in late March.

RADIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: THEODORE J. PFEFFER, M.D., Milwaukee
President, Wisconsin Radiological Society

10:00—INFUSION PYELOGRAPHY

June Unger, M.D., Wood
Veterans Administration Medical Center

10:15—VENOUS PHASE—CEREBRAL ANGIOGRAPHY

James Nellen, M.D., Milwaukee

10:35—PEDIATRIC RADIOLOGICAL TECHNIQUE

Donald Babbitt, M.D., Milwaukee

10:55—SAME DAY RE-ENFORCEMENT CHOLECYSTOGRAPHY

Andrew B. Crummy, M.D., Madison

11:10—RECESS TO VIEW EXHIBITS

12:15—RADIOLOGY LUNCHEONS (See notice below)

(Afternoon Session)

Moderator: JOSEPH WEPFER, M.D., Milwaukee

2:00—RADIOLOGICAL TREATMENT OF DEGENERATIVE JOINT DISEASE

Gordon D. ViGario, M.D., and Halvor Vermund, M.D., Madison
Department of Radiology, University of Wisconsin Medical School

2:15—TOPIC PENDING

Kurt Amplatz, M.D., Minneapolis
Associate Professor of Radiology, University of Minnesota School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:45—LOWER ESOPHAGEAL RING

Richard Schatzki, M.D., Boston
Assistant Clinical Professor of Radiology, Harvard Medical School, Massachusetts

4:15—TOPIC PENDING

John Amberg, M.D., Milwaukee
Associate

4:35—BUSINESS MEETING OF SECTION ON RADIOLOGY

NOTE: During noon hour, both Doctors Amplatz and Schatzki will conduct luncheon discussions. Details on this will reach members late in March.

In the evening the Wisconsin Radiological Society will have a dinner (members only) with Doctor Schatzki as speaker. Reservations for this will be made with the Secretary of the Radiological Society after notice on the dinner is sent all members.

HOUSE OF DELEGATES

BALLROOM, HOTEL SCHROEDER

(Evening Session)

7:00—The Second Session of the House of Delegates will be held at the Hotel Schroeder on Tuesday evening.

FIRESIDE CONFERENCES

FIFTH FLOOR, HOTEL SCHROEDER

(Evening Session)

8:00—The Wisconsin Chapter of the American College of Chest Physicians will present a series of informal "Fireside Conferences" on a variety of subjects, in the East Room and Pere Marquette Room of the Hotel Schroeder. Program arranged by SYDNEY T. GETTELMAN, M.D., West Allis. Free beer for all those in attendance!

1. CHRONIC AND DEGENERATIVE LUNG DISEASE
   - (a) EMPHYSEMA
   - (b) CHRONIC BRONCHITIS
   - (c) PULMONARY FIBROSIS
   - (d) BRONCHIECTASIS
   - ETC.
2. MANAGEMENT OF CARDIOPULMONARY EMERGENCIES
   - (a) CARDIAC RESUSCITATION
   - (b) DRUG AND INHALATION THERAPY—RECENT ADVANCES
3. INFECTIOUS DISEASES OF LUNG—VIRAL, BACTERIAL, FUNGAL, AND TUBERCULOUS

   PROBLEMS RELATING TO MANAGEMENT
4. ALLERGIC PULMONARY DISEASE AND ASTHMA

   INCLUDING VASCULITIS AND CONNECTIVE TISSUE DISORDERS
5. CHEST X-RAY READING
6. PROBLEMS OF ELECTROCARDIOGRAPHIC INTERPRETATION
7. VALUE OF PHYSICAL EXAMINATION OF THE HEART

8. INFLAMMATORY DISEASES OF THE HEART
   (a) RHEUMATIC DISEASE
   (b) PERICARDITIS
   (c) MYOCARDITIS
   ETC.

9. MANAGEMENT OF HYPERTENSIVE DISEASE; CORONARY DISEASE AND CARDIAC DECOMPENSATION; EMPHASIS ON ADVANCES IN DRUG THERAPY

10. DIAGNOSIS AND MANAGEMENT OF VALVULAR AND CONGENITAL HEART DISEASES—MEDICAL AND SURGICAL ADVANCES

11. MALIGNANT AND BENIGN NEOPLASTIC DISEASES OF THE CHEST—DIAGNOSTIC TECHNIQUES AND MANAGEMENT

WEDNESDAY, MAY 5

Two general programs have been developed for the morning period, 10 a.m. to 12 noon, and special programs on the subjects of Dermatology, Pediatrics, and Orthopedic and Plastic Surgery have been arranged for the afternoon.

PROGRAMS PREPARED IN COOPERATION WITH:

Wisconsin Academy of General Practice
Wisconsin Dermatological Society
Wisconsin Society of Orthopedic Surgery
Wisconsin Chapter, American Academy of Pediatrics

GENERAL PRACTICE

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: W. D. HAMLIN, M.D., Mineral Point
President, Wisconsin Academy of General Practice

10:00—AUTOIMMUNE DISEASE

Carl M. Pearson, M.D., Los Angeles

Associate Professor of Medicine, University of California School of Medicine

10:45—RECESS TO VIEW EXHIBITS

11:15—PANEL ON "ASTHMA"

Moderator: CHARLES REED, M.D., Madison
(Participants will be listed in March issue of the Journal)

NOTE: A noon luncheon will be conducted by Doctor Pearson. Details on this will reach members in late March.

DERMATOLOGY-PEDIATRICS

Wet Clinic on "Adolescence"

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: ROBERT B. PITTELKOW, M.D., Milwaukee

10:00—CASE REVIEWS AND DISCUSSIONS

Actual cases will be provided by Milwaukee dermatologists, and special discussants will be:

Carl W. Laymon, M.D., Minneapolis

Clinical Professor of Dermatology, University of Minnesota School of Medicine, and

Arthur Roth, M.D., Oakland, Calif.

10:45—RECESS TO VIEW EXHIBITS

11:15—CONTINUATION OF CASES AND DISCUSSION

NOTE: Both Doctors Laymon and Roth will conduct noon luncheon discussions. Details will reach members in late March.

DERMATOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: RICHARD ROWE, M.D., Marshfield
President, Wisconsin Dermatological Society

2:00—DERMAL SCLEROSES

Carl W. Laymon, M.D., Minneapolis

Clinical Professor of Dermatology, University of Minnesota School of Medicine

2:45—RECESS TO VIEW EXHIBITS

3:15—TOPIC PENDING

Sture A. M. Johnson, M.D., Madison

Professor of Dermatology, University of Wisconsin Medical School

3:35—THE RADIOLOGIST LOOK AT DERMAL SCLEROSIS

F. Frank Zboralske, M.D., Milwaukee

Assistant Professor of Radiology, Marquette University School of Medicine

ORTHOPEDIC SURGERY AND PLASTIC SURGERY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: HERMAN W. WIRKA, M.D., Madison
President, Wisconsin Society of Orthopedic Surgery

2:00—SURGERY OF RHEUMATOID ARTHRITIS

Leonard Marmor, M.D., Los Angeles

Assistant Professor of Orthopedic Surgery, University of California School of Medicine

WEDNESDAY *continued*

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—DEGENERATIVE HIP DISEASE

Carroll B. Larson, M.D., Iowa City

Professor and Chairman of the Department of Orthopedic Surgery, State University of Iowa College of Medicine

4:30—DISCUSSION

NOTE: Doctor Marmor will conduct a noon luncheon program. Details on this will reach members in late March.

The Wisconsin Society of Orthopedic Surgery will have a dinner (members only), with Doctor Larson as speaker. Members will receive a notice on this from the Secretary of the Wisconsin Orthopedic Society.

PEDIATRICS

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: STEWART GRIGGS, M.D., Green Bay
President, Wisconsin Chapter of the American Academy of Pediatrics

2:00—ADOLESCENTS AND THEIR PROBLEMS: Physical and Mental

Arthur Roth, M.D., Oakland, Calif.

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—INFORMING AND TEACHING PARENTS OF DISTURBED CHILDREN

Thomas Linton, Ph.D., Milwaukee

NOTE: Doctor Roth will conduct one of the noon luncheon conferences. Details on this will reach members in late March.

PRESIDENT'S RECEPTION AND ANNUAL DINNER

BALLROOM, HOTEL SCHROEDER—7:15 p.m.

President Curran has decreed that the Annual Dinner will be strictly social and will follow the theme of "an evening of Fun and Fellowship." The Marquette Medical School Glee Club will sing during the Dinner. Dancing, during dinner and following a floor show, will be provided by Grant Krueger and His Orchestra "The Executives." Following brief talks by the President and the President-Elect, and granting of special citations, the remainder of the evening will be a floor show and dancing! PLAN TO ATTEND AND HAVE FUN WITH YOUR WIFE AND OTHER COUPLES WHO WILL BE IN ATTENDANCE.

THURSDAY, MAY 6

Special Program Presented by Residents of Wisconsin Hospitals

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

This is a special feature which we hope will be attended by many members of the State Medical Society. The six contestants will present papers and a panel of three judges will select the two best, each to receive a cash award:

$100—The William S. Middleton Lecture
$100—The Harry Beckman Lecture

Winning lectures will be published in the Wisconsin Medical Journal

Judges are: OVID O. MEYER, M.D., Madison, Member of Commission on Scientific Medicine; VICTOR S. FALK, M.D., Edgerton, Medical Editor of the Wisconsin Medical Journal; and NORBERT BAUCH, M.D., Milwaukee, representing the Wisconsin Academy of General Practice

(Morning Session)

Moderator: P. T. BLAND, M.D., Westby
Chairman, Commission on Scientific Medicine

10:00—THE USE OF PERITONEAL LAVAGE IN THE TREATMENT OF ACUTE PANCREATITIS IN DOGS

Larry C. Carey, M.D., Milwaukee

Resident in Surgery, Milwaukee County Hospital

10:15—Discussant: E. H. ELLISON, M.D., Milwaukee

10:20—MERCURY INTOXICATION SIMULATING INTRA-ABDOMINAL SURGICAL CONDITIONS

Walter Schwindt, M.D., Madison

Resident in General Surgery, University Hospitals

10:35—Discussant: ROBERT C. HICKEY, M.D., Madison

10:40—THE ANATOMICAL ISOLATION OF THE DOG BRAIN FOR USE AS A RESEARCH TOOL

Morris B. Glover, M.D., Madison

Resident in Neurosurgery, University Hospitals

10:55—Discussant: M. J. JAVID, M.D., Madison

11:00—PARTIAL GASTRECTOMY FOR PEPTIC ULCER DISEASE

John E. Clemons, M.D., La Crosse

Resident in General Surgery, Lutheran Hospital

11:15—Discussant: TO BE ANNOUNCED

11:20—SIX MONTHS' EXPERIENCE WITH CARDIO-RESPIRATORY RESUSCITATION

Philip J. Tangher, M.D., Marshfield

Resident in Medicine, St. Joseph Hospital

THURSDAY *continued*

11:35—Discussant: DEAN EMANUEL, M.D., Marshfield

11:40—THE NATURAL HISTORY OF METAPHYSEAL DYSOSTOSIS

Arlan L. Rosenbloom, M.D., Madison

Resident in Pediatrics, University Hospitals

11:55—Discussant: HENRY OKAGAKI, M.D., Madison

12:00—DECISION OF JUDGES ON WINNING PAPERS

OTOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: LEE EBY, M.D., Milwaukee

10:00—SIGNIFICANCE AND EVALUATION OF NECK SWELLING

Francis L. Lederer, M.D., Chicago

Professor and Head of the Department of Otolaryngology, University of Illinois College of Medicine

10:45—RECESS TO VIEW EXHIBITS

11:00—PANEL ON "CARCINOMA OF THE LARYNX"

Moderator: FRANCIS L. LEDERER, M.D., Chicago

Anthony Grueninger, M.D., Milwaukee
Robert Johnson, M.D., Madison
Rollo Lange, M.D., Madison
Patrick Noonan, M.D., Milwaukee

NOTE: *At noon the otologists will join the ophthalmologists for lunch and a business meeting as the Section on EENT. Following lunch and the business meeting there will be a special program on ophthalmology, and all those interested are urged to attend.*

ANESTHESIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: SHERMAN C. MYERS, M.D., Milwaukee
President, Wisconsin Society of Anesthesiologists

2:00—THE SELECTION AND MANAGEMENT OF ANESTHESIA IN CARDIAC PATIENTS

E. M. Papper, M.D., New York City

Director of Anesthesiology Service, Presbyterian Hospital, New York

2:30—RESPIRATORY PHYSIOLOGY OF THE NEWBORN

David Allen, M.D., Chicago

Director, Department of Anesthesiology, Children's Memorial Hospital, Illinois

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON "THE PLACE AND VALUE OF INHALATION THERAPY IN THE PRE- AND POSTOPERATIVE PERIOD

Moderator: JAMES BARBOUR, M.D., Madison

E. M. Papper, M.D., New York City
David Allen, M.D., Chicago
Karl Siebecker, M.D., Madison
J. J. Jacoby, M.D., Milwaukee

NOTE: *Both Doctors Papper and Allen will conduct noon luncheon discussions. Details will reach members in late March.*

In the evening the Wisconsin Society of Anesthesiologists will hold a dinner (members and wives only) and social gathering. Members will receive a notice on this from the Secretary of the Wisconsin Society of Anesthesiologists.

OPHTHALMOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

All ophthalmologists and otolaryngologists will meet for lunch in Juneau Hall at 12:15 p.m., as the Section on EENT. Following the business meeting (around 1 p.m.), there will be a special program on ophthalmology.

Moderator: MATTHEW D. DAVIS, M.D., Madison

2:00—TOPIC PENDING

Samuel J. Kimura, M.D., San Francisco

Associate Professor of Ophthalmology, University of California

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:30—PROGRAM TO BE ANNOUNCED

SURGERY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: NORMAN BECKER, M.D., Fond du Lac
President, Wisconsin Surgical Society

2:00—THE TREATMENT OF ULCERATIVE LESIONS OF THE STOMACH AND DUODENUM

(William Beaumont Memorial Lecture of the CES Foundation of the State Medical Society of Wisconsin)

Alton Ochsner, M.D., New Orleans

Ochsner Clinic

NOTE: *Balance of the program being arranged by the Wisconsin Surgical Society and will be carried in the March issue of the Wisconsin Medical Journal.*

The Wisconsin Surgical Society will conduct a dinner on Thursday evening. Notice will reach members of the Wisconsin Surgical Society through John Mendenhall, M.D., Madison, Secretary.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Milton Gutglass, and Dr. and Mrs. Robert Pittelkow, Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 3–6, 1965

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Milton Gutglass, Milwaukee, on or before April 1, 1965. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwaukee Auditorium between 8:30 a.m. and 10:00 a.m., Monday, May 3, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Wednesday, May 6.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Milton Gutglass, 7426 North Crossway Road, Milwaukee, Wis. 53217, BEFORE APRIL 1, 1965.

I plan to submit the following entry or entries for the 1965 MEDICAL ART SALON at the Milwaukee Auditorium, May 3–6.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

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1965 **Wisconsin**

Mar. 16, 17, 18: Circuit Teaching Programs, State Medical Society, at Sheboygan, Marinette, and Antigo.

Mar. 27–28: Wisconsin Psychiatric Association, Milwaukee chapter, two-day course for general practitioners, Coach House, Milwaukee, cosponsored by Wisconsin Academy of General Practice, Department of Psychiatry at Marquette University School of Medicine, and Milwaukee Sanitarium Foundation

Mar. 30, 31, Apr. 1: Circuit Teaching Programs, State Medical Society, at Appleton, Wisconsin Rapids, and Rice Lake.

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 1–3: University of Wisconsin Department of Pediatrics, annual postgraduate seminar, "Importance of Immune Mechanisms in Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

Apr. 3–4: Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology Spring Meeting at Sheboygan.

Apr. 5–8: National Association of Recreational Therapists, annual institute, Wisconsin Center, University of Wisconsin, Madison.

Apr. 8, 15, 22, 29: Postgraduate course in Therapy of Infectious Diseases, Marquette University School of Medicine, Milwaukee.

Apr. 14: Symposium on Anxiety, Northwest Psychiatric Clinic, Eau Claire.

Apr. 10: Endocrine Seminar, Marshfield Clinic Foundation for Medical Research and Education, Marshfield.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 10–12: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

Mar. 22–26: American College of Physicians golden anniversary session, Conrad Hilton Hotel, Chicago, Ill.

Mar 24: Wayne State University, 7th annual "Resident's Day" in obstetrics and gynecology, Wayne County Medical Society Building, 1010 Antietam St. at Rivard, Detroit, Mich.

Mar. 24–26: 1965 Sight-Saving Conference, National Society for Prevention of Blindness, Houston, Tex.

Mar. 26–27: 18th National Conference on Rural Health, AMA Council on Rural Health, Miami Beach, Fla.

Mar. 28–Apr. 1: International Anesthesia Research Society, 39th congress, Washington, D. C.

Mar. 29–Apr. 10: Postgraduate course in laryngology and bronchoesophagology given by Department of Otolaryngology, College of Medicine of University of Illinois, at Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill.

Mar. 31–Apr. 2: Medical education symposium on gastroenterology, Medical College of Georgia, Augusta, Ga.

Apr. 2–4: 21st Annual Meeting, American Society for Study of Sterility, San Francisco, Calif.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 5–8: American industrial health conference, sponsored by Industrial Medical Association and American Association of Industrial Nurses, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 6: 7th Howard Fox Memorial Lecture, New York University School of Medicine, Department of Dermatology, New York, N. Y.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

MEDICAL MEETINGS

POSTGRADUATE COURSES

Apr 21–24: Methodist Hospital Graduate Medical Center Department of Otolaryngology, in cooperation with American Rhinologic Society, introductory course in expanded surgery of nasal septum at medical center, Indianapolis, Ind.

Apr. 26–29: American Academy of Pediatrics, spring session, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 26–29: 36th Annual Scientific Meeting, Aerospace Medical Association, New York City.

Apr. 28–May 1: 9th Postgraduate course in Trauma, Chicago Committee on Trauma of American College of Surgeons, Chicago, Ill.

May 1–2: Seminar on Chronic Obstructive Lung Disease, Medical College of Georgia, Augusta, Ga.

May 14–15: Fifth Institute on Preventive Psychiatry, sponsored by University of Iowa Preventive Psychiatry Committee, University of Iowa, Iowa City.

May 21–23: Tri-State meeting of Illinois, Iowa, and Wisconsin Associations of Blood Banks, Davenport, Ia.

May 30–June 3: Medical Library Association Annual Meeting, Philadelphia, Pa.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 14–17: American Proctologic Society, 64th annual meeting, Minneapolis, Minn.

June 16: Scientific Session of American Cancer Society, Philadelphia, Pa.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30–Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Marquette U Postgraduate Course

Marquette University School of Medicine and the Milwaukee Children's Hospital announce a postgraduate course in pediatrics to be held from 7 to 9:30 p.m. March 3, 10, 17, and 24 in the Amphitheater of Milwaukee Children's Hospital, 1700 W. Wisconsin Ave., Milwaukee.

Dr. John C. Peterson, professor and chairman of Marquette's Department of Pediatrics, will be director of the course and visiting professor will be Dr. Fred Blodgett, associate professor of pediatrics at Yale University School of Medicine, New Haven, Conn.

The American Academy of General Practice is allowing 10 credit hours for the course. Tuition is $10, but there is no charge for residents, interns, or medical students.

Reservations should be sent to: Joseph W. Rastetter, M.D., Director Postgraduate Medical Education Programs, Marquette University School of Medicine, 8700 W. Wisconsin Avenue, Milwaukee, Wis. 53226.

Final UW Program

The final "In Depth" teaching program of the University of Wisconsin Medical School will be presented Thursday, March 18, on the subject, "Endocrine Problems in Gynecology." Like the others in the series, this program was planned cooperatively with the State Medical Society and the Madison Chapter of the Wisconsin Academy of General Practice.

Guest lecturer will be Dr. Hilton Salhanick, Boston. University of Wisconsin faculty members who will participate include Dr. Edwin Albright, Dr. A. L. Kennan, Dr. William Kiekhofer, Dr. Ben M. Peckham, and Dr. Arlan J. Rosenbloom.

The course will deal with the diagnosis and management of certain problems in the field of gynecologic endocrinology. Between 10 a.m. and noon at University Hospitals, patients will be presented exhibiting thyroid, adrenal, and ovarian dysfunction. Following lunch at SMS headquarters, there will be short presentations on related topics, concluding with a panel discussion with audience participation.

Any licensed physician is permitted to attend the program, which provides AAGP educational credit. The registration fee of $5.00 covers lunch and special parking at University Hospitals. Those wishing to register should write Roy T. Ragatz, State Medical Society, Box 1109, Madison, 53701. The covering check for registration should be made payable to the CES Foundation.

Mayo Clinical Reviews

Again this year, the staff of the Mayo Clinic and the faculty of Mayo Foundation, Rochester, Minn., are presenting Clinical Reviews, a program of lectures and discussions on problems of general interest in medicine and surgery. Because of the large number attending in past years, two identical sessions will again be presented on successive weeks. The first is scheduled for March 15, 16, and 17 and the second on March 22, 23, and 24 in the theater of the Mayo Civic Auditorium in Rochester.

The program is acceptable for credit by the American Academy of General Practice and the College of General Practice of Canada. Registration fee is $10. Those wishing to attend should communicate with M. G. Brataas, Mayo Clinic, Rochester, Minn., indicating which session they would prefer to attend.

Wisconsin–Upper Michigan Society

The spring meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology is slated for the weekend of April 3–4 at Sheboygan.

Speakers will include Dr. Brian McCabe, professor, Department of Otolaryngology and Maxillofacial Surgery of the State University of Iowa, who will discuss diseases of the major salivary glands and the "dizzy patient;" Merle Lawrence, Ph.D., director of Kresge Hearing Research Institute, University of Michigan Medical School, and Dr. Richard O. Schultz, assistant professor and chairman of the Department of Ophthalmology, Marquette University School of Medicine.

The two-day program will include an evening session at the Pine Hills Country Club.

Endocrine Seminar at Marshfield

The Marshfield Clinic Foundation for Medical Research and Education is presenting an Endocrine Seminar on Saturday, April 10, in the Marshfield Clinic Library. Subject will be: "Diseases of the Pituitary Gland." Dr. Raymond Randall, endocrinologist from the Mayo Clinic at Rochester, Minn., will be the guest consultant.

The program will open at 9 a.m. with an address on hypopituitarism by Doctor Randall, with presentation of patients (Sheehan's syndrome) following. At 10:30 a.m. Doctor Randall will speak on "Syndromes of Hyperpituitarism," again to be followed by presentation of patients (acromegaly, chromophobe adenoma).

At the afternoon session, topics discussed will be "Diseases of the Posterior Pituitary" and "New Concepts of Hypothalamic and Pituitary Disease." After the first discussion, patients will be presented exhibiting psychogenic polydipsia, inappropriate ADH syndrome.

The seminar is announced by the Section of Endocrinology: Drs. R. S. Baldwin, G. J. Coombs, F. N. Lohrenz, and T. F. Nikolai.

WHA Guest Speakers Announced

Guest speakers for the 17th annual meeting and scientific sessions of the Wisconsin Heart Association have been announced by WHA's physician education committee. The meeting has been scheduled for May 15 at the Coach House Motor Inn, 1926 W. Wisconsin Ave., Milwaukee.

Highlighting the corporate luncheon program will be an address by Dr. W. Randolph Lovelace II, director of space medicine, Office of Manned Space Flight, National Aeronautics and Space Administration, Washington, D.C. His subject will be "Current Aerospace Medical Research Program."

Guest speakers presenting papers at the scientific sessions will include Dr. Hadley L. Conn, Jr., Philadelphia, who will speak on coronary heart disease; Dr. Donald B. Effler, Cleveland, surgical correction of acquired and coronary heart disease; Dr. William T. Mustard, chief of cardiovascular surgery, Hospital for Sick Children, Toronto, Ont., congenital heart disease, and Dr. Homer R. Warner, chief of the cardiovascular laboratory, Latter-Day Saints Hospital, Salt Lake City, Utah, who will speak on computer diagnosis.

International Conference in Madrid

Leaders of the International Union for Health Education met in Paris recently to complete planning for the sixth International Conference on Health and Health Education July 10–17 in Madrid, Spain.

A large group from the United States is expected to participate in the conference, whose theme will be "The Health of the Community and the Dynamics of Development." Special travel arrangements including post-conference study tours to Western Europe, Eastern Europe, and Russia, have been made in response to wide interest in participation. Announcement was made by the president of the American National Council for Health Education of the Public, Inc., Dr. L. E. Burney, former surgeon general of the U.S. Public Health Service.

For full details, interested individuals are asked to write to ANCHEP, 800 Second Ave., New York, N.Y. 10017.

Dearholt Days

David T. Smith, M.D., professor of microbiology and associate professor of medicine at Duke University Medical Center, will be the speaker at the 1965 Dearholt Days lectures to be held in Madison March 17 and Milwaukee March 18.

The Madison talk will be held at 4 p.m. in the auditorium, Service Memorial Institute, University of Wisconsin and in Milwaukee at 4 p.m. at Coffey Auditorium, Milwaukee County General Hospital.

Doctor Smith's topic is, "The Prevalence of Atypical or Unclassified Mycobacteria in the United States and A Reevaluation of the Standard Tuberculin Skin Test in Diagnosis and Prognosis."

Dearholt Days, which began in 1940, had Doctor Smith as speaker in 1942. The series is sponsored by the Wisconsin Anti-Tuberculosis Association.

The scientist is author of 155 publications, among them a book on "Fusopirochetal Diseases." He also was co-author of a Manual of Clinical Mycology and senior author of Zinsser's Textbook of Bacteriology.

He served as president of the National Tuberculosis Association from 1950–51 and is a member of the Director's and Examining Board of that group.

The Dearholt Days lectures were begun to honor the life and contributions to medicine and public health of Hoyt E. Dearholt, M.D., founder and executive secretary of the WATA from 1909 to 1939.

AMA–ABA to Sponsor Medicolegal Symposium

One of the largest and most significant meetings on medicine and the law will be held in Las Vegas on March 11–13.

Sponsored by the American Medical Association and the American Bar Association, the National Medicolegal Symposium at The Dunes hotel will feature 41 participants.

They include: retired U.S. Supreme Court Justice Charles E. Whittaker; the Honorable Grant Sawyer, Governor of Nevada; Joseph F. Sadusk, Jr., M.D., medical director of the Food and Drug Administration and chairman of AMA's Committee on Medicolegal Problems; four judges; a law school dean; ten physicians; and 23 attorneys.

Speaking on behalf of the AMA-ABA Liaison Committee, co-chairmen Percy E. Hopkins, M.D., and Thomas Boodell, stated:

"This is the first time that the AMA and the ABA are jointly sponsoring a National Medicolegal Symposium. By combining the resources of our two organizations, we have been able to gather an impressive array of speakers.

"This promises to be one of the largest and most significant medicolegal meetings ever held. It will be a giant step in improving the administration of justice and in promoting harmonious relations between the medical and legal professions."

A discussion, *The Legal Advisor—What Every Physician Should Know*, on Friday morning will be moderated by George M. Fister, M.D., Ogden, Utah, a past president of the AMA. Legal advice on personal and professional matters and the physician's annual legal checkup will be presented by three speakers—Robert B. Murphy, Madison, Wis.; C. Dean Davis, Austin, Tex., and Philip Habermann, Madison, Wis.

Advance registrations for the symposium may be made by writing directly to Robert B. Throckmorton, general counsel, American Medical Association, 535 North Dearborn, Chicago, Ill. 60610. The advance registration fee of $25 covers the cost of the luncheon, a reception and a copy of the proceedings. The check should be made out to the American Medical Association. Registrants are to make their own hotel reservations.

N.A.R.T. Annual Institute

The National Association of Recreational Therapists (N.A.R.T.) will hold its annual institute April 5 through April 8, 1965, at the Wisconsin Center, University of Wisconsin, Madison. Institute theme is "Recreation; Education; Re-creation." Several speakers, workshops, and discussion groups, encompassing all areas concerned with the rehabilitation of handicapped people, will be featured at this institute.

The N.A.R.T. is encouraging people in all related fields to attend. A program highlight will be announced at a later date.

Meeting Slated on Rural Health Resources

Means of providing full-range health services for the nation's 60,000,000 rural residents will be discussed at the 18th National Conference on Rural Health March 26–27 in Miami Beach. The American Medical Association's Council on Rural Health is sponsoring the meeting, at which matters that will be discussed by farm and medical leaders will be implementation of programs for financing hospital and doctor costs among rural residents.

A feature of the March 26 afternoon session will be a panel discussion on "Practical Implementation of Health Care Programs." Among the participants will be Dr. John Allen, Madison, director of medical services in the Wisconsin State Department of Public Welfare.

Dr. Edward R. Annis, Miami, AMA past president, will speak at a banquet that evening.

Aerospace Medical Association Meeting

More than 2500 of the world's foremost specialists in aerospace and aviation medicine and the allied sciences are expected to attend the 36th annual scientific meeting of the Aerospace Medical Association April 26–29 at the New York Hilton Hotel, New York City.

A meeting highlight will be presentation of the 11th Annual Louis H. Bauer Lecture by Dr. H. Guyford Stever, recently named president of Carnegie Institute of Technology, Pittsburgh, Pa.

Ninth Postgraduate Course in Trauma

The ninth postgraduate course in trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 28 through May 1 at the John B. Murphy Memorial Auditorium, 50 E. Erie St., Chicago, Ill. 60611.

Among the distinguished teachers and surgeons comprising the faculty will be Dr. Jorg Bohler, professor of accident surgery at the University of Vienna and eminent orthopedic surgeon of Linz, Austria, who will deliver eight lectures. Registration fee is $75.

Howard Fox Memorial Lecture

The Department of Dermatology of New York University School of Medicine announces the seventh Howard Fox Memorial Lecture to be delivered by Dr. O. Braun-Falco, professor and chairman, Department of Dermatology, University of Marburg, West Germany, on Tuesday, April 6, at 3:45 p.m. in Alumni Hall, 550 First Ave., New York, N.Y. The title of Doctor Braun-Falco's talk will be "The Pathogenetic Mechanisms of Alopecias."

American Cancer Society Program

Dr. Roald N. Grant, Director of Professional Education of the American Cancer Society, has announced the program for the 1965 Scientific Session of the Society to be held at the Drake Hotel in Philadelphia on June 16. This symposium on "Hormones and Chemotherapy for Cancer—A Critical Appraisal" is open to all members of the medical and dental professions, and students. There is no advance registration or registration fee. For further information, write: Director of Professional Education, American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017. The program follows:

HORMONES AND CHEMOTHERAPY FOR CANCER—A CRITICAL APPRAISAL

Problems and Pitfalls in the Evaluation of Chemotherapy, Dr. David A. Karnofsky, Memorial Hospital, New York, N. Y.

Nature and Example of Joint Clinical Studies, Dr. Lyndon Lee, Jr., Veterans Administration, Washington, D. C.
Discussion, Dr. Michael Shimkin, Temple University School of Medicine, Philadelphia, Pennsylvania.

THERAPY IN ADVANCED BREAST CARCINOMA (EXCLUDING RADIATION): *a. Castration in Advanced Breast Cancer,* Dr. Edward F. Lewison, Johns Hopkins Hospital, Baltimore, Maryland; *b. Chemotherapy in Advanced Breast Carcinoma,* Dr. Michael J. Brennan, Henry Ford Hospital, Detroit, Michigan; *c. Hormone Therapy in Advanced Breast Cancer,* Dr. B. J. Kennedy, University Hospital, Minneapolis, Minnesota.
Discussion, Dr. Robert G. Ravdin, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania.

Chemotherapy of Chorioepithelioma and Related Trophoblastic Diseases, Dr. Griff T. Ross, National Cancer Institute, Bethesda, Maryland.
Discussion, Dr. Warren R. Lang, Jefferson Medical College, Philadelphia, Pennsylvania.

CARCINOMA OF THE OVARY AND UTERUS: *a. Arterial Infusion Chemotherapy for Carcinoma of the Ovary and Uterus,* Dr. C. Paul Hodgkinson, Henry Ford Hospital, Detroit, Michigan; *b. Chemotherapy for Carcinoma of the Ovary and Uterus,* Dr. Sydney Kofman, Presbyterian-St. Luke's Hospital, Chicago, Illinois; *c. Progestational Agents for Carcinoma of the Endometrium,* Dr. Robert W. Kistner, Harvard Medical School, Brookline, Massachusetts.
Discussion, Dr. George C. Lewis, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

MELANOMA AND ADJUVANT THERAPY: *a. Chemotherapy for the Treatment of Melanoma,* Dr. Donald B. Rochlin, University of California Medical Center, Los Angeles, California; *b. Adjuvant Chemotherapy,* Dr. Warren H. Cole, University of Illinois College of Medicine, Chicago, Illinois.
Discussion, Dr. George P. Rosemond, Temple University School of Medicine and Hospital, Philadelphia, Pennsylvania.

Chemotherapy in Childhood Cancer (Except Leukemia), Dr. W. W. Sutow, M. D., Anderson Hospital & Tumor Institute, Houston, Texas.

Combined Chemotherapy and Radiation for Solid Tumors in Adults, Dr. Vernon H. Reynolds, Vanderbilt University, Nashville, Tennessee.
Discussion, Dr. C. Everett Koop, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.

Chemotherapy for Lymphomas and Leukemias, Dr. Emil Frei, III, National Cancer Institute, Bethesda, Maryland.
Discussion, Dr. Timothy R. Talbot, Institute for Cancer Research, Philadelphia, Pennsylvania.

The Molecular Biology of Development, Dr. James Bonner, California Institute of Technology, Pasadena, California.

ENDOCRINE SEMINAR

in

Marshfield, Wisconsin

Saturday, April 10, 1965

9:30 A.M.

DR. RAYMOND RANDALL

of the Mayo Clinic

GUEST CONSULTANT

Subject: Diseases of the Pituitary

MARSHFIELD CLINIC LIBRARY

Presented by the Marshfield Clinic Foundation
for Medical Research and Education

S.M.S. AND U. OF W. "IN DEPTH" PROGRAMS RATED HIGHLY SUCCESSFUL

The second series of the U. of W. "In Depth" teaching programs was rated highly successful by participants as it reached the halfway mark with the January 28 program on Colon and Rectal Surgery. Some 70 physicians viewed actual operations at University Hospitals via closed circuit TV during the morning session at the University. At noon they lunched at the State Medical Society headquarters and then heard lectures during the afternoon. Dr. Robert Turell of New York City was the guest lecturer.

The one-day teaching programs are presented by the State Medical Society and the University of Wisconsin Medical School in cooperation with the Madison Chapter of the Wisconsin Academy of General Practice. The programs are supported in part by the Merck, Sharp & Dohme Postgraduate Program.

THE PRESIDENTS ROOM at the State Medical Society building where "In Depth" lectures are presented is shown at the top during the Colon and Rectal Surgery session January 28. Pictured above are the U.W. faculty and the guest lecturer: Drs. Robert Samp, S. A. M. Johnson, Frank Weston, Robert Turell, Robert Hickey, Kenneth Lemmer, and John Benfield.

Marquette Postgraduate Course

Marquette University School of Medicine and the Milwaukee County General Hospital announce a postgraduate course in THERAPY OF INFECTIOUS DISEASES April 8, 15, 22 and 29, King Conference Room (fifth floor), Milwaukee County General Hospital, 8700 West Wisconsin Avenue, Milwaukee.

Director of the course is Burton A. Waisbren, M.D., associate clinical professor of medicine. Eight hours allowed by the AAGP. Tuition: $25.00 (no charge for residents, interns, or medical students). Send reservations to: Joseph W. Rastetter, M.D., Director Postgraduate Medical Education Programs, Marquette University School of Medicine, 8700 West Wisconsin Avenue, Milwaukee, Wis. 53226.

Symposium on Anxiety at Eau Claire

A Symposium on Anxiety will be held at the Eau Claire Country Club, Eau Claire, April 14, sponsored by the Northwest Psychiatric Clinic. The program will begin at 1 p.m. with a welcome by Dr. L. J. Ganser, director, Division of Mental Hygiene, State Department of Public Welfare, Madison. Speakers and their topics include the following:

Howard Rome, M.D., Mayo Clinic, Rochester, Minn., president-elect, American Psychiatric Asso-

INVITATION TO DENTAL SOCIETY MEETING

Members of the State Medical Society of Wisconsin are invited by Dr. T. E. Ryan, president of the Wisconsin State Dental Society, to attend the scientific program of the society's 95th Annual Session at the Milwaukee Auditorium, May 10–12. The theme of this year's program will be: "Meeting Dentistry's Challenge." Guest badges allowing admittance to the meeting may be obtained in the registration area at the Kilbourn Avenue entrance. The only identification needed is your current medical society membership card.

ciation: *Recognition of the Anxious Patient.* Peter F. Regan, III, M.D., vice-president for health affairs, State University of New York at Buffalo: *Nature of Anxiety.* Blaine McLaughlin, M.D., University of North Dakota, Grand Forks: *General Principles of Office Management.* Carl Fellner, M.D., University of Wisconsin, Madison: *Drug Treatment of Anxiety.* A discussion period will follow these afternoon lectures.

Following dinner the lectures will continue. Kenneth Appel, M.D., University of Pennsylvania, past president of the APA, will speak on *Impact of Anxiety on Society and the Individual.* He will be followed by Richard Sternbach, Ph.D., University of Wisconsin, Madison, whose topic will be *Principles of Psychophysiological Disorders.*

There will be case presentations, *Illustrative Examples of Systemtic Involvement.* Moderator will be Dr. B. H. Glover, Eau Claire, and participants, Drs. Glen Giffen (cardiovascular), Eau Claire; William Wright (idiopathic fluid retention), Mondovi; and L. A. Raymond (respiratory), Eau Claire. A discussion period will end the program.

OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the October 1963 and May 1964 sessions of the House of Delegates, are being published in the February and March, 1965, issues of the WISCONSIN MEDICAL JOURNAL.

Constitutional Amendment Introduced in October 1963 for Action in May 1965

Resolved, That Article VIII, Section 3, of the Constitution of The State Medical Society of Wisconsin be amended by striking out the present Section 3 of Article VIII and substituting the following Section:

"SECTION 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called."

Constitutional Amendment Introduced in May 1964 for action in May 1965

Resolved, That no individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and that no more than a total of six terms of service as councilor shall be permitted; and be it further

Resolved, That the above provision be inserted in Section 2, Article IX, of the Constitution.

"CIRCUITS" TO SERVE NORTHERN COUNTIES IN MARCH

March 16: Sheboygan
March 17: Marinette
March 18: Antigo
March 30: Appleton
March 31: Wisconsin Rapids
April 1: Rice Lake

The Commission on Scientific Medicine has arranged two Circuit Teaching Programs for physicians in northern Wisconsin areas, as indicated above.

Faculty members for the March 16–17–18 circuit are: *John Morledge,* M.D., clinical instructor in medicine, UW; *Anthony Pisciotta,* M.D., associate professor of medicine, Marquette; and *James Cherry,* M.D., assistant professor of pediatrics, UW. Subjects to be discussed are Coronary Disease, Hypertensive Drugs, Anemia, Hematologic Drug Reactions, Viral Exanthems, and Respiratory Virus Infections.

For the March 30–31–April 1 meetings, instruction will be provided by *Richard Mattingly,* M.D., professor and chairman of the Department of Obstetrics and Gynecology, Marquette; *George Collentine,* M.D., assistant clinical professor of surgery, Marquette; and *Robert Donaldson,* M.D., assistant professor of medicine, UW. Doctor Mattingly will cover Emergency Treatment of the Third Trimester "Bleeder" and Hazard of Drugs in Obstetrics, while Doctors Collentine and Donaldson will cover, jointly, The Treatment of Pancreatitis. Doctor Collentine will also discuss Colon-Rectal Polyps while Doctor Donaldson will discuss Dysphagia.

Programs will be held during the afternoon, followed by a dinner and evening question period. The cost of $6.00 covers everything. Educational credit of 5 hours is provided for AAGP members who attend.

Advance reservations requested. Send to: Roy T. Ragatz, Assistant Secretary, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701; and make your check payable to: CES Foundation. Indicate clearly which meeting you will attend.

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BOOKS RECEIVED

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BILHARZIASIS

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1962. 433 pages. Price: $11.50.

FUNDAMENTALS OF VOLUNTARY HEALTH CARE

Edited by George B. de Huszar. The Caxton Printers, Ltd., Caldwell, Idaho. 1962. 457 pages. Price: $6.00.

SYNOPSIS OF NEUROLOGY

By Francis M. Forster, B.S., M.D., Professor and Chairman, Department of Neurology, University of Wisconsin School of Medicine, Madison, Wis. C. V. Mosby Co., St. Louis, Mo. 1962. 223 pages. Price: $6.75.

PEDIATRIC SURGERY

By Orvar Swenson, M.D., Surgeon-in-chief, The Children's Memorial Hospital, Chicago; Professor of Surgery, Northwestern University Medical School. Appleton-Century-Crofts, New York, N. Y. 1962. 779 pages. Price: $20.00.

THORACIC SURGERY

Volume I. Surgery in World War II: Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-chief, Col. John Boyd Coates, Jr., M.C., Editor for Thoracic Surgery, Frank B. Berry, M.D., Associate Editor, Elizabeth M. McFetridge, M.A., Office of the Surgeon General, Department of the Army, Washington, D. C., 1963. 394 pages.

AN INTRODUCTION TO PSYCHIATRY

By Kurt Kolle. Philosophical Library, New York, N. Y. 1963. 71 pages. Price: $3.00.

PERSUASION AND HEALING

A Comparative Study of Psychotherapy. By Jerome D. Frank, M.D., Ph.D. The Johns Hopkins Press, Baltimore. 1961. 282 pages. Price: $5.50.

DICTIONARY OF EROTIC LITERATURE

By Harry E. Wedeck, Lecturer in Classics, Brooklyn College, N. Y.. Fellow, International Institute of Arts and Letters. Philosophical Library, New York, N. Y. 1962. 556 pages. Price: $10.00.

COMMUNICABLE AND INFECTIOUS DISEASES

By Franklin H. Top, A.B., M.D., M.P.H., F.A.C.P., F.A.A.P., F.A.P.H.A., Professor and Head, Department of Hygiene and Preventive Medicine, and Director, University Department of Health and Institute of Agricultural Medicine, State University of Iowa, Iowa City. 5th edition. C. V. Mosby Co., St. Louis, Mo. 1964. 902 pages. Price: $21.00.

PREVENTIVE MEDICINE IN WORLD WAR II

Volume VI. Communicable Diseases—Malaria. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C.; Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D.; Assistant Editor, Phebe M. Hoff, M.A. Office of the Surgeon General, Department of the Army, Washington, D. C. 1963. 642 pages.

ORGANIZATION AND ADMINISTRATION IN WORLD WAR II

Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C.; Editor for Organization and Administration, Charles M. Wiltse, Ph.D., Litt.D. Office of the Surgeon General, Department of the Army, Washington, D. C. 1963. 613 pages.

SURGERY IN WORLD WAR II—ACTIVITIES OF SURGICAL CONSULTANTS

Volume II. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C.; Editor for Activities of Surgical Consultants, B. Noland Carter, M.D.; Associate Editor, Elizabeth M. McFetridge, M.A. Office of the Surgeon General, Department of the Army, Washington, D. C. 1964. 1062 pages.

PERSONNEL IN WORLD WAR II

Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C.; Editor for Personnel, Charles M. Wiltse, Ph.D., Litt.D. Office of the Surgeon General, Department of the Army, Washington, D. C. 1963. 548 pages.

TEXTBOOK OF OTOLARYNGOLOGY

By David D. DeWeese, M.D., Professor and Chairman of the Department of Otolaryngology, University of Oregon Medical School, Portland, Ore., and William H. Saunders, M.D., Professor and Chairman of the Department of Otolaryngology, The Ohio State University College of Medicine, Columbus, Ohio. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 523 pages. Price: $9.25.

EXPERIMENTAL PHARMACODYNAMICS

By T. Koppanyi and A. G. Karczmar. 3rd edition. Burgess Publishing Co., Minneapolis 15, Minn. 1963. 246 pages. Price: $6.50.

PATIENT CARE AND SPECIAL PROCEDURES IN X-RAY TECHNOLOGY

By Carol Hocking Vennes, R.N., B.S., Part-time Clinical Instructor and former Surgical Supervisor and Clinical Instructor, University of Minnesota Hospital, Minneapolis, and John C. Watson, R.T., Technical Consultant, Department of Radiology, Yale Medical Center and Grace–New Haven Community Hospital, New Haven, Conn.; former Director of Courses in X-Ray Technology, University of Minnesota Hospitals, Minneapolis. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 228 pages. Price: $6.25.

BOOKSHELF *continued*

1963–1964 COLLECTED PAPERS IN MEDICINE AND SURGERY FROM THE MAYO CLINIC AND THE MAYO FOUNDATION

Volume 55. Compiled by Werner Heidel, M.D. W. B. Saunders Co., Philadelphia and London. 1964. Medicine: 552 pages. Surgery: 585 pages. Price: $25.00 a set; $13.50 singly.

THE HISTORY OF PROSTITUTION

By Vern L. Bullough, Ph.D.; Bonnie L. Bullough, M.S., Research Associate. University Books, New Hyde Park, N. Y. 1964. 304 pages. Price: $7.50.

BETTER HEALTH FOR WOMEN

By Charles Richard Alsop Gilbert, M.D., F.A.C.S., F.A.C.O.G., F.A.S.A.S., Diplomate Section of Obstetrics and Gynecology, Pan American Medical Society, Diplomate American Board of Obstetrics and Gynecology. Doubleday & Co., Inc., Garden City, N. Y. 1964. 365 pages. Price: $4.95.

CONSULTATIONS IN MEDICINE: COMMON COMPLAINTS

A collection of medical articles from CONSULTANT magazine. Published by Smith Kline & French Laboratories, Philadelphia, Pa. 19101. 1964. 206 pages. Price: $3.00.

HIPPOCRATES: THE THEORY AND PRACTICE OF MEDICINE

General Editors, Dagobert D. Runes and Thomas Kiernan, with Introduction by Emerson Crosby Kelly, M.D. Philosophical Library, Inc., New York 16, N. Y. 1964. 374 pages. Price: $7.50.

SYNOPSIS OF PATHOLOGY

By W. A. D. Anderson, M.D., F.A.C.P., F.C.A.P., Professor of Pathology, University of Miami School of Medicine, Coral Gables, Fla.; Director of Pathology Laboratories, Jackson Memorial Hospital, Miami, Fla. 6th edition. C. V. Mosby Co., St. Louis, Mo. 1964. 883 pages. Price: $9.75.

MODERN TREATMENT

Volume 1, No. 1. Treatment of Renal Disease, by Guest Editor, E. Lovell Becker, M.D., and Treatment of Thyroid Disease, by Guest Editor, Edward A. Carr, Jr., M.D. Hoeber Medical Division, Harper and Row, Publishers. Published bimonthly at 49 East 33rd Street, New York, N. Y. 10016. 228 pages in first issue. Subscription: $16.00 per year.

Volume 1, No. 2. Treatment of Pulmonary Diseases, by Guest Editor, Carl Muschenheim, M.D., and Treatment of Liver Disease, by Guest Editor, Richard B. Capps, M.D. 526 pages.

Volume 1, No. 3. Treatment of the Anemias, by Guest Editor, Edwin D. Bayrd, M.D., and Treatment of Cardiac Arrhythmias, by Guest Editors, J. Willis Hurst, M.D., and Robert C. Schlant, M.D. 789 pages.

Volume 1, No. 4. Treatment of Infectious Diseases, by Guest Editor, Lowell A. Rantz, M.D. 1033 pages.

A DOCTOR TALKS TO 9-TO-12-YEAR-OLDS

By Marion O. Lerrigo, Ph.D., in consultation with Michael A. Cassidy, M.D. Budlong Press Co., Chicago, Ill. 60625. 1964. 75 pages. Price: $1.50. Includes booklet, "Your Child from 9-to-12, by same authors. 27 pages.

DIET AND BODILY CONSTITUTION

Ciba Foundation Study Group No. 17; edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1964. 120 pages. Price: $2.95.

HANDBOOK OF OBSTETRICS & GYNECOLOGY

By Ralph C. Benson, M.D., Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Oregon Medical School, Hospitals, and Clinic, Portland, Ore. Lange Medical Publications, Los Altos, Calif. 1964. 659 pages. Price: $5.00.

ANIMAL BEHAVIOUR AND DRUG ACTION

Ciba Foundation Symposium Jointly with the Co-ordinating Committee for Symposia on Drug Action. Hannah Steinberg, Ph.D., Editor for the Co-ordinating Committee. A.V.S. deReuck, M.Sc., D.I.C., and Julie Knight, B.A., Editors for the Ciba Foundation. Little, Brown and Co., Boston. 1964. 491 pages. Price: $13.00.

CELLULAR INJURY

Ciba Foundation Symposium. Edited by A.V.S. deReuck, M.Sc., D.I.C., A.R.C.S., and Julie Knight, B.A. Little, Brown and Co., Boston. 1964. 403 pages. Price: $12.00.

BRAIN–THYROID RELATIONSHIPS

Ciba Foundation Study Group No. 18. Edited by Margaret P. Cameron, M.A., and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1964. 117 pages. Price: $1.95.

AETIOLOGY OF DIABETES MELLITUS AND ITS COMPLICATIONS

Ciba Foundation Colloquia on Endocrinology. Volume XV. Edited by Margaret P. Cameron, M.A., and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1964. 405 pages. Price: $12.50.

BOOK REVIEWS

WOMEN AND FATIGUE

A Woman Doctor's Answer. By Marion Hilliard, M.D. Doubleday & Co., Inc., Garden City, New York, 1960. 175 pages. Price: $2.95.

This attractively printed volume of small size is written in a conversational manner to inform the public concerning the factors of fatigue and their psychosomatic relationship to a variety of complaints. This is not a new theme but it is developed in a more psychologically acceptable manner by Doctor Hilliard. Based chiefly on modified Freudian ideas, the development of the book proceeds along orderly lines in a somewhat anecdotal fashion to emphasize the emotional forces that lie within us and their gross influence upon our muscular tensions, our bony framework, and our glandular functions. The book is definitely written for the lay public and is easily readable in a few hours. One of the more popular chapters is related to common sense and calories. Marriage, sex, family life, children, and the premarital experiences of dating and of menstrual problems are all touched upon in an informative manner.

This is not a profound book. It is a general knowledge book, somewhat like a lay medical advice text. It is a rather motherly type of volume and at times overly solicitous perhaps but nonetheless carries its message in simple form to that large group of

following infection

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Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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women who have been called the "chronically fatigued." The price at $2.95 seems reasonable for the content and the readers to whom it is directed.—B. H. GLOVER, M.D.

CURRENT GASTROENTEROLOGY

Edited by Gordon McHardy, M.D., Clinical Professor of Medicine, Louisiana State University School of Medicine, Paul B. Hoeber, Inc., Medical Division of Harper & Brothers, New York, 1962. 674 pages. Price: $16.50.

There has been a need for many years for a textbook of gastroenterology which would provide an authoritative reference source for internists and general physicians. This need is only partially fulfilled by Doctor McHardy's book. The book contains a collection of papers which were presented at a postgraduate course held in New Orleans in 1960 under the joint sponsorship of the American Gastroenterological Association and the American College of Physicians. The list of authors includes most of the leading authorities in the field of gastroenterology so that the material presented is authoritative and relatively current.

The book suffers from an attempt to condense 57 papers into 664 pages of text. The book is weakened further by what seems to this reviewer to be an inappropriate length of treatment of various subjects. Only 39 pages are devoted to diseases of the esophagus, yet 57 pages are devoted to a single presentation of the paper electrophoretic patterns of gastric juice. The important subject of tests of intestinal absorption is presented only in outline form. The 75-page symposium on peptic ulcer is excellent and should be read by all physicians who are called upon to treat this disease. Because of the brief discussions of most subjects, the book is of limited value as a reference source for the gastroenterologist, yet space is devoted to topics such as esophageal dilatation, gastroscopic photography, and mucosal biopsy which are not of interest to general physicians.—JOHN F. MORRISSEY, M.D.

THE GOLDEN AGE COOKBOOK

By Phyllis MacDonald. Doubleday & Co., Inc., Garden City, New York, 1961. 192 pages. Price: $2.95.

The Golden Age Cookbook is one that should meet a real need of older people who may consider meal planning and preparation a chore. Well prepared, regularly eaten meals contribute much to the enjoyment of retirement years and good food habits are vital to health.

The book is primarily a cookbook rather than a nutrition text, but simple balanced menus suggest a pattern which should be easy to follow and meet the requirements of good nutrition.

The book is written in popular style and is easy to read. In addition, to the section on balanced diet, appetizing recipes and menus, there are sections on selection of easy-to-use equipment and festive foods

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Indications
Many types of edema involving retention of salt and water.
Contraindications
Hypersensitivity, and most cases of severe renal or hepatic disease.
Precautions
Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects
Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage
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Availability
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for parties. Safety precautions are suggested in organization of work areas of the kitchen.

An attractive feature of the book is the fact that it is written for use by a family of one or two people.

Easy-to-prepare foods and use of planned leftovers may help to meet the problems of persons who wish to plan enjoyable meals with the least expenditure of energy. "Capsule Kitchen" meals gives attention to meals cooked with small appliances.

At least one hot food at every meal and eating at regular times are rules that if followed should help the older person conserve health and vigor.

Menus are planned according to seasons with easy-to-prepare recipes accompanying them. Winter menus emphasize the need for enough of the important foods such as meats, vegetables, milk and citrus fruits. One section of the book gives ideas for soft foods that meet food requirements.

Inexpensive and easily prepared meals for the visits of the children and grandchildren provide for preparations which can be made the day before.

This book designed for people of retirement age should appeal not only to that age group but should be of interest to couples or those who live alone whatever their age. Food must be appetizing and attractive to have an appeal, and we believe *The Golden Age Cookbook* will meet a real need.—EDITH BANGHAM, M.S.

THE LIFE EXTENSION FOUNDATION GUIDE TO BETTER HEALTH

By Harry J. J. Johnson, M.D., President, The Life Extension Foundation. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959. 220 pages. Price: $4.95.

Dr. Johnson's *Guide to Better Health* has all the earmarks of a compilation of medical columns such as one reads by Dr. Crane, Dr. Brady, and Dr. Molner. One is suspicious that the ideas are more personal opinions than scientific data gathered by the Life Extension Foundation. Nonetheless, the advice is conservative, sound, and legitimate.

Although no best seller, the book is easy to read and interesting. It is of value to the practicing physician; first, to check his ideas against the authors and second, to catch up with the information given the public. The latter point is very important because this type of book is readily accepted by the public who feel they are gaining an inside track or "confidential" look at what one doctor reports to others.—ROBERT J. SAMP, M.D.

EYE SYMPTOMS IN BRAIN TUMORS

By Alfred Huber, M.D., Private Dozent for Ophthalmology at the University of Zurich, Zurich, Switzerland. C. V. Mosby Co., St. Louis, Mo., 1961. 329 pages. Price: $16.00.

This compact book is a welcome addition to the literature of neuro-ophthalmology. It is well written, fully and beautifully illustrated. Doctor Huber, who is trained in both ophthalmology and neurology, based the material of this book on 1,600 cases of intracranial neoplasms examined in the Neurosurgical Clinic of the University of Zurich in Switzerland. Stephen van Wien, M.D. should be congratulated for the beautiful and lucid translation of this book into the English language.

The first chapter emphasized the importance of a very careful history. It gives, in detail, the numerous methods in clinical examination used in the diagnosis of an intracranial tumor. The second chapter deals mainly with the ocular aspect of increased intracranial pressure. It has a comprehensive description of papilledema and its differential diagnosis.

Next, the ocular manifestation of various brain tumors are described on a regional basis preceded by a brief summary of general neurologic syndromes.

The final chapter deals with the so-called "pseudo" tumors, e.g. subdural hematoma, brain abscess, and aneurysms.

It is a pleasure to recommend this book to physicians in every branch of medicine, particularly as this publication is an excellent reference for the practitioner who is often confronted with apparent papilledema.—GUILLERMO B. DE VENECIA, M.D.

REHABILITATION OF A CHILD'S EYES

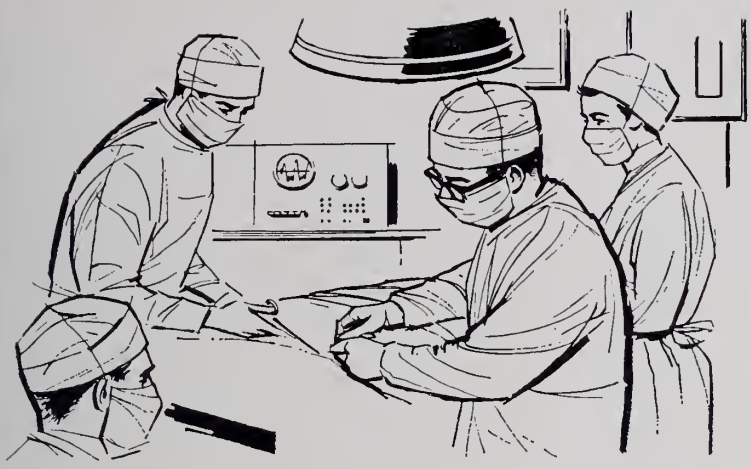
By Herbert M. Katzin, M.D., F.A.C.S., Director & Board Member, Eye Bank Laboratory, and Attending Surgeon, Manhattan Eye, Ear and Throat Hospital, New York, N. Y. C. V. Mosby Co., St. Louis, Mo., 1961. 107 pages. Price: $3.75.

This is the third edition of the late Dr. Richard G. Scobee's original work on strabismus in children. Doctor Katzin and Miss Wilson, an orthoptic technician, have done an excellent job in keeping this volume up to date and presenting in a brief 103 pages the essence of the management of strabismus in children.

The primary purpose of this book is to inform and educate the parents of strabismic children regarding the etiology of strabismus and its proper treatment by means of glasses, orthoptic training, medical means, and surgery. It serves this purpose well and would also serve as a quick and practical refresher course for general practitioners and pediatricians who may have lost touch with modern therapy for strabismus.

The chapters on the etiology of strabismus, the explanation of the accommodative convergence mechanism with why and how glasses may improve strabismus and the surgical management of strabismus are particularly good.

The only criticism this reviewer would have to offer is the rather heavy stress on orthoptic exercises or so-called "visual" training in the treatment of these youngsters. Although the effectiveness of orthoptics in the preoperative and postoperative management of many cases is not open to question, Doctor Katzin, practicing in New York City, may fail to recognize that the services of a trained orthoptic technician are not available to the average ophthalmologist. These technicians are ordinarily unavailable outside of the larger cities, thus making



Signs and symbols may change . . . but not the basic medical tradition of broad social responsibility.

In the 1880s Wisconsin physicians participated in a program to protect lumber camp workers from financial loss due to injury or sickness. The idea was an innovation in a time when disabled workers were not regularly reimbursed for occupational injuries. Wisconsin went on to pass America's first Workmen's Compensation Law in 1911.

Medicine in 1965 is more complex than medical practice in 1880, but the guiding principles of the early pioneers are still with us. The physicians of the State Medical Society who guide WPS are ever alert to the rapid advances in modern medicine and in maintaining the "service-to-mankind" concept of medicine in making sure that those needing medical care are not financially burdened by it.

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their services too expensive in both time and money for the average patient living in suburban or rural areas.—FREDERICK J. DAVIS, M.D.

A TRAVELER'S GUIDE TO GOOD HEALTH

The Do's and Don'ts of Staying Healthy While Seeing the World. By Colter Rule, M.D. Doubleday & Co., Inc., Garden City, New York, 1960. 240 pages. Price: 95¢.

This book answers a clear need to assist the many travelers in the maintenance of their health while in foreign countries. The book has 236 pages and a good index.

There are 22 chapters in the book which begin with general common sense medical advice, immunizations necessary for travel, the wardrobe, and motion problems. Then specific problems in drinking water and in foreign food are discussed including very helpful hints on how to insure avoidance of digestive upsets. The next five chapters deal with simple personal hygiene rules for care and management of simple medical problems such as digestive upsets, skin disease, eye trouble, colds, orthopedic problems, and overheating. A traveler's kit of important medicines to take on the trip is then outlined in detail. There is a good chapter on some of the leads on finding a physician abroad. A short chapter on first aid emergency is given and then a variety of miscellaneous ills are discussed ranging from allergy to hangovers to varicose veins. Problems that are met in traveling with children and with pets are discussed, and there is a special section on hazards in the tropics. The author then discusses historical and biological background for different immunizations. Finally there is a chapter on the psychology of travel.

In an appendix consisting of four sections, there is a medical gazetteer dealing with specific health hazards in different main sections of the world and a glossary of medical terms translated into French, German, English, Italian, and Spanish. There is also useful information on inversion of weights and measures and on certain physiologic facts. This reviewer feels this to be an excellent and very useful book. In the reviewer's opinion, the author says too much about the general background of personal hygiene and too little about the specific problems in health that would be encountered in different individual countries. However, this book or one like it deserves a place in the handbag of every foreign traveler.—ALFRED S. EVANS, M.D.

THE COMPLEAT PEDIATRICIAN

By Wilburt C. Davison, M.D., Professor of Pediatrics, Duke University Medical Center; and Jeana Davison Revinthal, M.D., Research Associate, Harvard Medical School. 257 pages. Price: $4.50.

The eighth edition of *The Compleat Pediatrician* has the same structure and format as the previous

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editions, and according to the author it has been completely revised to keep abreast of recent medical advances. There is little doubt that this book contains reference to every condition, disease, symptom or syndrone that could occur in pediatrics and thus can properly be called compleat. It is a useful volume for obtaining a list of possibilities involved in a differential diagnosis or finding the major points of some bizarre syndrome. The arrangement of the book is sometimes confusing with footnotes to the third or fourth power, but this can be mastered with some practice and the information found.

The authors of this book are eager to give long lists of the diseases possible in a differential, or to list any symptom remotely possible in discussing a disease, but they become dogmatic when they discuss treatment. Instead of allowing that several forms of treatment might be effective, they usually cover only one and all too often one of questionable value. Such statements as, "an ice pack on the chest is essential in the treatment of pericarditis," "newborns should have nothing by mouth for the first 24 hours," "rocking or walking the floor (with an infant) is harmful," are not in agreement with standard practice. These are three examples, but many more can be found in the book. This type of unbalance seriously detracts from the usefulness of this volume since the unsuspecting student is unable to detect the controversial points.

In summary, this book may have its use in locating bizarre symptoms or syndromes, but it should serve only as a beginning, and more complete works should be consulted on matters of management and treatment.—H. K. TENNEY, III, M.D.

WPS Improves "Century" Benefits

Wisconsin Physicians Service, the insurance plan of the State Medical Society, has announced that the WPS Century Plan insurance policy (surgical-medical, hospital, nursing home, and sanitarium coverage for persons 65 and over) is now available with hospital room rate benefits increased from 20 to 50 per cent.

Present subscribers may keep their current policy, or increase their protection to benefits available under the revised plan. Applicants may continue to enroll throughout the year.

The WPS Century Plan was developed and offered to the public almost six years ago and at present more than 15,000 Wisconsin residents are covered by this policy.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the SMS Commission on Medical Care Plans, points out that the plan includes a full payment feature for those with modest incomes.

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INDICATIONS: Poor circulation causing cold hands and feet or pain on walking. For the more serious peripheral vascular disturbances such as . . . Raynaud's Disease, Meniere's Syndrome, intermittent claudication, diabetes, post-phlebitis syndrome, leg ulcers due to venostasis and chronic thrombophlebitis.

DOSAGE: 1 or 2 teaspoonfuls or 1 or 2 tablets 3 times a day before meals. The feeling of warmth and tingling of the skin is a desirable effect. If this reaction is too pronounced reduce dosage.

CONTRAINDICATIONS: There are no known contraindications.

SUPPLIED: 8 oz. bottles and bottles of 100 chew-tabs.

FORMULA: Each teaspoonful (5ml.) contains:
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in a palatable Sherry Wine Base
Alcohol 5%
Each lemon flavored chew-tab contains:
Nicotinic Acid ..... 75 mg.
Glycine .....750 mg.

REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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unique properties make the difference in difficult or routine cases

In acute and chronic urinary tract infections, Terramycin provides rapid, high concentrations of antibiotic in G.U. tract structures and in their blood supply, as well as in the urine itself. A greater likelihood of therapeutic success is therefore afforded even in cases resistant to other antibiotics. Foret,[1] for example, obtained satisfactory control in 34 of 48 patients with chronic stubborn genitourinary infections, almost half of which had failed to respond to previous antibiotic therapy.

No other single broad-spectrum antibiotic has been more widely employed in such a great variety of infections—common or difficult—caused by gram-positive or gram-negative bacteria, spirochetes, rickettsiae, protozoa and large viruses, as well as bacteroids and *Enterobius vermicularis.*

Adding to its versatility is a unique variety of dosage forms. For example, only Terramycin among the broad-spectrum antibiotics is available as a *preconstituted solution for I.M. use.* Always ready for immediate injection, it requires no refrigeration and remains stable for at least two years.

Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record—confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low.

[1]Foret, J.: Antibiot. Ann. 1958-1959:253.

OUR CRITICS

AFL–CIO president George Meany told a press conference recently that the American Medical Association was making "cynical claims that no federal action is required" in the field of medical care for the aged, and he dismissed Eldercare as "empty promises." The press conference was held in plush Bal Harbour, Florida, an expensively luxurious winter resort for the nation's wealthy folks, where, by odd coincidence, the leaders of the nation's rank-and-file laboring folks ofttimes hold their conventions.

Surrounded by the well-heeled citizenry who have the loot and the leisure to loll in the relaxing rays of a midwinter sun in a subtropical clime, the executive council of the AFL–CIO had just reaffirmed its support of the Johnson administration's medicare bill which Meany thinks will at last become a reality after five years of his up-to-now futile support. In his press conference Meany condemned Eldercare because it proposes medical assistance only for those who need it; it follows the not unreasonable premise that those who don't need financial assistance shouldn't be offered it. A quick look at his fellow guests at the Bal Harbour spa should have suggested to him that there is a substantial section of the population to whom the benefits of medicare are really less than nothing.

It is interesting to notice, however, the basis for Meany's criticism of the AMA plan. He emphasizes the show-of-need provision of Eldercare, which is significant mainly to the citizen who doesn't need financial assistance for medical care. Those who truly need the financial assistance offered will have no problem with the simple requirement to show eligibility; the something-for-nothing people would have difficulty.

Like many other labor leaders and proponents of the administration's plan, Meany seems to ignore the important differences between the two plans, particularly that the AMA plan offers far more benefits for the total health care of the aged. The King–Anderson medicare bill offers, quite simply, hospital care for all, including Mr. Meany's fellow vacationers in the Florida sun. The alternative Herlong–Curtis Eldercare bill offers non-surgical doctor's care, surgery, drugs, and outpatient care as well as hospitalization and nursing home care, and all of this without a payroll tax increase. By any objective standard, the AMA proposal offers more and is much more realistic in terms of the medical requirements of the aged. It also proposes amendments to the Internal Revenue Code which would give tax breaks to those who contribute to the financial assistance of relatives over 65 and to those taxpayers over 65 who have medical expenses. But Meany and the other labor leaders allude not at all to these interesting features. He merely condemns them as "empty promises."

Meany and the proponents of the King–Anderson bill are entitled to their opinion, of course, and if they like medicare, they have a right to support it. But in a serious debate on a matter of grave national importance, it is incumbent on responsible leadership to discuss the issues in a responsible manner. Name-calling and blanket condemnation do not contribute to understanding, and in this instance the tactic of obfuscating the issues does a disservice to the entire nation. If the AFL–CIO believes it has a patriotic obligation to help secure the best possible medical care for the country's elder citizens, it is clearly derelict in its duty when it persists in an unreasonable attack on the motives of the supporters of the Eldercare plan, without discussing the plan itself.

—D.N.G.

COUNTY SOCIETY PROCEEDINGS

BARRON–WASHBURN–SAWYER–BURNETT

Dr. Henry Peters, associate professor of neurology at the University of Wisconsin Medical School, was the speaker and election of officers was the principal business on the agenda when the Barron–Washburn–Sawyer–Burnett County Medical Society met December 8, 1964, at the King Edward Inn, Rice Lake.

Doctor Peters spoke on the subject of Porphyria. Elected to office at the meeting were *Dr. Donald Welter*, Shell Lake, president; *Dr. Lloyd Cotts*, Rice Lake, vice-president; *Dr. Lloyd M. Baertsch*, Hayward, secretary; and *Dr. C. J. Strang*, Barron, delegate.

Announced at the meeting were the results of the recent elections at Lakeside and St. Joseph's Hospitals, Rice Lake. At Lakeside, officers are *Dr. M. E. Gillespie*, chief-of-staff; *Dr. James Maser*, vice-chief; and *Dr. Lloyd Cotts*, secretary. Officers at St. Joseph's are *Dr. John K. Hoyer*, chief-of-staff; *Dr. W. B. Rydell*, vice-chief; and *Dr. N. A. Eidsmoe*, secretary. All six physicians are from Rice Lake.

The group of 18 who attended the society's meeting on January 12 at King Edward Inn heard a paper by Dr. Lloyd Sherman, Minneapolis proctologist, on the topic, "Newer Treatment of Inflammatory Disease of the Colon." During their business session they voted to invite the chief administrator from the St. Paul Regional Red Cross Blood Bank to address the April meeting in order to discuss blood bank problems encountered in small hospitals.

BROWN

New officers of the Brown County Medical Society were unanimously elected at the organization's final meeting of 1964 on December 10 in the Northland Hotel, Green Bay.

GREEN BAY PRESS GAZETTE Photo

THREE COMMUNITY LEADERS received medical service awards as an expression of appreciation from the Brown County Medical Society at a luncheon in December at St. Vincent's Hospital, Green Bay. *Dr. Lyle Edelblute* presents the awards to, left to right, Hilary M. Lesperance, chairman of the Brown County Blood Procurement Program of the Red Cross; Norman N. Miller, member of the St. Mary's Hospital advisory board, and Lester G. Wood, president of the Bellin Memorial Hospital Board.

Physicians whose names appear in italics are members of the State Medical Society.

On the slate of 1965 officers presented by *Dr. L. H. Edelblute*, Green Bay, retiring president, were the names of *Drs. C. A. Wunsch*, president-elect; *K. C. Mickle*, secretary-treasurer; *A. J. McCarey*, censor 1965–1967; *B. P. Waldkirch* and *J. E. Dettmann*, delegates 1965–1966; and *Donel Sullivan* and *J. B. Grace*, alternates 1965–1966. All are Green Bay physicians with the exception of Doctor Waldkirch, who is from De Pere. Also from De Pere is *Dr. R. M. Waldkirch*, incoming president.

Retiring secretary of the society is *Dr. Frank Urban*, Green Bay.

In other business, *Dr. T. J. Beno*, Green Bay, told the 60 doctors in attendance that the society's volunteer system of emergency services had worked fairly well, but that more volunteers were needed. The emergency services should be the function of the hospital staffs, Doctor Beno indicated.

CHIPPEWA

Officers of the Chippewa County Medical Society, elected at the annual meeting the first week in December, are *Dr. Clifford Bowe*, Cadott, president; *Dr. Charles Kemper*, Chippewa Falls, vice-president; and *Dr. James Windeck*, Chippewa Falls, who was reelected secretary-treasurer.

CLARK

Dr. J. W. Koch, Colby, has been elected president of the Clark County Medical Society succeeding *Dr. E. D. Pfefferkorn*, also of Colby. *Dr. Bahri O. Gungor*, Neillsville, was named secretary.

COLUMBIA–MARQUETTE–ADAMS

Dr. Arthur Weihe, Friendship, was elected president of the Columbia–Marquette–Adams County Medical Society for 1965 at the society's meeting December 15, 1964, at Divine Savior Hospital in Portage. Elected secretary-treasurer was *Dr. Martin Janssen*, Adams.

The county-wide home nursing care program which began in Columbia County January 1 was established through the cooperation of the county society and the Columbia County Board of Supervisors. It is headed by Miss Sonja Smith, county health nurse, and an advisory committee of the county medical society headed by *Dr. James Macgregor*, Portage.

At the start, the program is being financed by funds received from the oral polio vaccine clinics held in the county early in 1964.

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Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
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—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

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Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

Salicylamide	250 mg.
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Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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DANE

At their first meeting of the new year, 150 members of the Dane County Medical Society had the privilege of hearing their distinguished colleague, *Dr. William S. Middleton*, address them on the subject, "The Ascendency of Iatrogenic Disorders." The dinner meeting was held January 12 in the Fireside Room at The Embers.

Photo courtesy WISCONSIN STATE JOURNAL

DR. WILLIAM S. MIDDLETON, center, his colleagues and long-time friends got together for a brief session following the surprise honor given him at the January 12 meeting of the Dane County Medical Society. On the left are Paul F. Clark, PhD, professor emeritus of medical microbiology at the University of Wisconsin, and Dr. Ovid O. Meyer, former chairman of the Department of Medicine at the UW; and on the right are C. H. Crownhart, secretary of the State Medical Society of Wisconsin, and Dr. William D. Stovall, retired head of the State Laboratory of Hygiene.

Doctor Middleton was surprised at the meeting when it was announced that the Dane County Medical Society is dedicating a sycamore tree to him. It will be planted at the State Medical Society headquarters in Madison. The tree is a relative of the plane tree of Greece under which Hippocrates is supposed to have practiced and taught medicine. Beneath the tree will be placed a bronze plaque with the inscription: IN TRIBUTE TO WILLIAM S. MIDDLETON, M.D., DISTINGUISHED TEACHER, SKILLED PHYSICIAN, ADMINISTRATOR, SCHOLAR, HISTORIAN, AND SOLDIER. The plaque was shown to Doctor Middleton and it now is on display at the State Medical Society building until the tree is planted.

DOUGLAS

Officers for 1965 were seated at Douglas County Medical Society's meeting January 6 at the Saratoga Cafe in Superior. They are: *Dr. Milton Finn*, Superior, president; *Dr. Victor E. Ekblad*, Superior, president-elect; *Dr. Oscar A. Farias*, Hawthorne, secretary-treasurer.

Dr. Albert L. Nisswandt, Duluth, Minn., neurosurgeon, presented an interesting program illustrated by slides on the topic, "Carotid Endarterectomies."

EAU CLAIRE–DUNN–PEPIN

New officers of Eau Claire–Dunn–Pepin County Medical Society are: *Dr. George E. Wahl*, president; *Dr. Richard C. Brown*, vice-president; *Dr. Harry Gonlag*, secretary-treasurer. All three are Eau Claire physicians.

At the society's meeting November 30, 1964, in Eau Claire, the speaker was *Dr. W. B. Larkin*, Marshfield otologist, whose subject was "The Surgery of Deafness." Slides and movies illustrated the talk.

GREEN

Members of the Green County Medical Society voted late in 1964 to use society funds and money left over after expenses were deducted from county immunization clinics for the purchase of several modern scientific facilities for St. Clare Hospital, Monroe.

GREEN LAKE–WAUSHARA

Election of officers featured the December 3 meeting of Green Lake–Waushara County Medical Society at Van Rhyans Steak House, Green Lake. New officers are *Dr. Alfred T. Leininger*, Green Lake, president; *Dr. L. J. Seward*, Berlin, vice-president; *Dr. John C. Koch*, Berlin, secretary-treasurer. *Dr. R. C. Darby*, Wautoma, was named delegate; *Dr. D. J. Sievers*, Berlin, alternate, and *Dr. Rodney Wichmann*, Wild Rose, censor.

Herbert Nolte of the Credit Bureau, Oshkosh, presented a film strip and short discussion on Credit Bureau activities.

JEFFERSON

The Jefferson County Medical Society, together with public health nursing services, announced at the end of 1964 that immunization clinics for Jefferson County adults would be held in January and February. Eight centers were scheduled beginning January 18, at which tetanus and smallpox vaccinations were to be given. A second series of eight centers was slated to begin February 15.

KENOSHA

Installation of officers featured Kenosha County Medical Society's first meeting of the new year on January 7 at the Elks Club in Kenosha.

Taking office were *Drs. R. G. Welsch*, president; *J. T. Duncan*, president-elect; *G. F. Armstrong*, secretary-treasurer; *R. A. Powell* and *Louis Olsman*,

delegates, and *W. C. Rattan* and *Morris Siegel*, alternate delegates. *Dr. C. A. Sattler* is the society's immediate past president.

LA CROSSE

At their last meeting of 1964 on December 21 at The Fireside, La Crosse, members of the La Crosse County Medical Society chose *Dr. Robert B. Rasmus* as their president-elect. Also named to office were *Dr. John J. Sevenants*, secretary-treasurer, and *Dr. George B. Murphy, Jr.*, delegate.

Dr. Mark O'Meara is the new president of the society succeeding *Dr. Frederick H. Wolf*.

New members are *Drs. Edward B. Miner* and *Robert M. Green*. All are LaCrosse physicians.

MILWAUKEE

When new officers of The Medical Society of Milwaukee County were seated December 10, 1964, at the society's annual meeting and election of officers, 226 physicians and guests were present for the occasion at the Milwaukee Athletic Club.

Dr. Robert F. Purtell took office as president succeeding *Dr. Robert S. Haukohl*, who was elected to serve on the board of directors. Also elected were *Dr. John J. Smith*, secretary, and *Dr. Thomas C. Lipscomb*, treasurer.

A special award of merit was presented to *Dr. Armand J. Quick*, professor emeritus and chairman of the Department of Biochemistry at Marquette University School of Medicine.

At their meeting on January 28, members of the society heard Dr. William A. Altemeier present a paper on "Postoperative Staphylococcal Enterocolitis." Doctor Altemeier is the Christian R. Holmes professor of surgery and chairman of the department of surgery at the University of Cincinnati, director of surgical services at Cincinnati General Hospital and surgeon-in-chief at Christian R. Holmes Hospital and Children's Hospital, Cincinnati.

Dr. William P. Crowley, Jr., Madison, chief medical consultant to the State of Wisconsin, spoke on policies in adjudicating claims for disability benefits under the Social Security Act.

RACINE

Officers of the Racine County Medical Society for 1965 are *Dr. Richard J. Mayer*, president; *Dr. William Kreul*, president-elect; *Dr. Elizabeth Steffen*, secretary; *Dr. Robert F. Scheller*, treasurer, and *Dr. Frank J. Scheible*, past president.

SHEBOYGAN

At the December 1964 meeting of the Sheboygan County Medical Society, *Dr. Robert M. Senty*, Sheboygan, was elected president succeeding *Dr. Donald Rowe*, Kohler.

Also named were *Dr. Irvin Schroeder*, Sheboygan, vice-president succeeding *Dr. James Hildebrand*, Sheboygan, and *Dr. James R. Hoon*, Sheboygan, secretary-treasurer succeeding *Dr. Joseph F. Kovacic*, Sheboygan.

In cooperation with the Sheboygan Municipal Health Department, the county medical society and Sheboygan Junior Chamber of Commerce conducted a repeat clinic December 6 at which 4,616 individuals were given oral polio vaccine. Members of the society administered the vaccine with the aid of numerous others.

WALWORTH

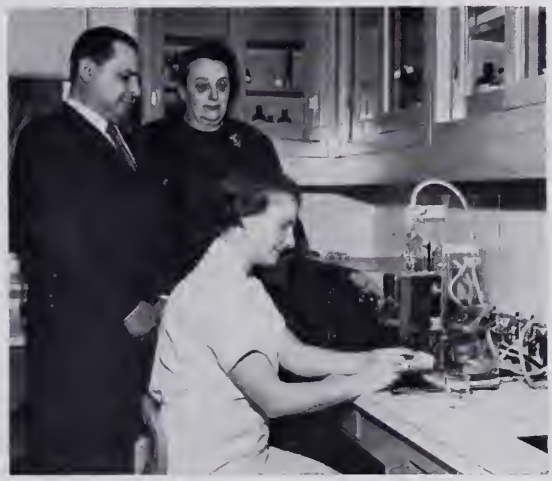

Photo courtesy ELKHORN INDEPENDENT

INTERESTED SPECTATORS as Mrs. Waldo Cordono, chief medical technologist, runs a blood count on Lakeland Hospital's new Coulter Counter, are Dr. R. S. Galgano, former secretary-treasurer of the Walworth County Medical Society, which purchased the $3,700 counter for the hospital's clinical laboratory, and Miss Margaret Schloemer, hospital administrator. About 400 counts a week are made at the hospital.

WAUKESHA

Dr. Richard G. Frantz, Waukesha, was chosen as president-elect of the Waukesha County Medical Society at a recent meeting at the Red Circle Inn. Others installed were *Dr. Thomas E. Dugan*, New Berlin, president; *Dr. W. E. Rosenkranz*, Mukwonago, secretary; and *Dr. Jerome R. Bischel*, Waukesha, treasurer.

WOOD

At a meeting on December 17, 1964, Wood County Medical Society members elected the following officers for 1965: *Dr. Richard J. Rowe*, Marshfield, president; *Dr. John W. Schaller*, Wisconsin Rapids, vice-president, and *Dr. Robert E. Bodmer*, Marshfield, secretary-treasurer.

Transfer of membership into the Wood County Society was accepted for two physicians, *Dr. Robert E. Carlovsky*, Marshfield, who was accepted from

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COUNTY SOCIETY PROCEEDINGS *continued*

the Denver Medical Society in Colorado, and *Dr. Albert M. Kinkella*, Marshfield, accepted as a transfer from the Sangamon County Medical Society in Illinois. *Dr. Clifford Starr*, Wisconsin Rapids, was elected to membership in April, 1964.

Speakers at the meeting were *Dr. William P. Crowley, Jr.*, Madison, and John O'Brien, Wisconsin Rapids. Doctor Crowley, who is chief medical consultant to the Wisconsin State Board of Vocational and Adult Education, Rehabilitation Division, Disability Determination Unit, spoke on the social security disability program. Mr. O'Brien is district manager for the Social Security Administration.

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SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

Dr. Vernon Knight, clinical director of the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Md., addressed the Milwaukee Academy of Medicine Tuesday evening, December 15, at the University Club of Milwaukee.

Dr. Morrison Schroeder was inducted as president of the Milwaukee Academy of Medicine at the group's 79th annual dinner meeting January 19 at the University Club of Milwaukee. Others elected for 1965 are: *Drs. F. Jackson Stoddard*, president-elect; *Edward A. Bachhuber*, vice-president; *Robert W. Byrne*, secretary; *Robert A. Frisch*, treasurer; *Richard D. Fritz*, librarian, and *Shimpei Sakaguchi*, membership committee chairman. Retiring president of the academy is *Dr. Donald M. Ruch*.

"Computers, Medicine, and the Physical Sciences" was the subject discussed by Dr. James V. Maloney, Department of Surgery, School of Medicine, University of California, Los Angeles.

Wisconsin Valley Chapter, AAGP

Dr. F. C. Kroeplin, Stratford, was elected president of the Wisconsin Valley Chapter of the Wisconsin Academy of General Practice at a business meeting at the Holiday Inn, Wausau, in December 1964. Others elected were *Dr. T. C. Fox*, Antigo, vice-president succeeding *Dr. B. K. Smith*, Wausau, and *Dr. C. M. Balliet*, Wausau, reelected secretary-treasurer.

Dr. Walter Lewinnek, Merrill, the chapter's retiring president, was moderator for a panel discussion conducted following dinner by the three Marquette University professors who were featured speakers at the afternoon symposium presented by the Wisconsin Academy of General Practice. The three were *Drs. Norman H. Engbring, John R. Litzow*, and *John A. Arkins*.

Douglas County Medical Assistants

Plans for a membership drive were discussed when the Douglas County Medical Assistants Society met January 12 at the Superior Memorial Hospital, Superior. Mrs. Lorraine Jacobson is membership chairman. Membership pins were discussed by Mrs. Lillian Dietrich.

Guest speaker at the meeting was *Dr. Milton Finn*, new president of the Douglas County Medical Society.

Triological Society

In spite of inclement weather, 134 otolaryngologists from throughout the mid-United States and Canada gathered in Madison January 23–24 for the meeting of the Middle Section of the American Laryngological, Rhinological, and Otological Society (The Triological Society).

The program took place exactly as planned and was extremely well received, according to *Dr. Maxine Bennett*, meeting coordinator. Doctor Bennett is professor and chairman of the Division of Otolaryngology of the University's Department of Surgery.

Dodge County Medical Assistants

New officers of the Dodge County Medical Assistants Society were installed on January 5 by Mrs. Aleen Piepenburg, Waukesha, president of the Wisconsin State Medical Assistants Society.

Taking office were Miss Sally LaFleur, president; Miss Sylvia Neumann, president-elect; Mrs. Marie Swain, recording secretary, and Mrs. Bonnie Straseski, treasurer. Mrs. Madeline Stebbins, the society's immediate past president, was presented with a gift.

Waukesha Medical Assistants

The Waukesha County Chapter of Medical Assistants recently demonstrated observance of Community Health Week in Waukesha. An eye-catching booth was set up in the lobby of a downtown bank on October 23. A colorfully draped table, denoting the Waukesha Chapter and the Wisconsin State Medical Assistants insignia, displayed a variety of pamphlets from the AMA and Waukesha County Health Department. A huge replica of the new AMA Community Health Week Seal, "Teaming Up For Better Health," served as the appropriate background.

WAUKESHA MEDICAL ASSISTANTS. Left to right: Mrs. Peggy Gallagher, president of the Waukesha County Chapter; Mrs. Aleen Piepenburg, president of the Wisconsin State Medical Assistants Society and member of the Waukesha Chapter, and Mrs. Lauren Smith, a visitor at the booth.

Physicians whose names appear in italics are members of the State Medical Society.

kills Haemophilus influenzae in respiratory infections

Electron micrograph of normal H. influenzae *organism.*

Electron micrograph of H. influenzae *after a 2-hour exposure to a therapeutic (8γ/ml.) dose of PENBRITIN (ampicillin)*

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Contraindications: (1) Hypersensitivity to penicillin (2) Infections by penicillinase-producing staphylococ or other penicillinase-producing organisms.

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Supplied: No. 606—Each capsule contains 250 mg. ampicillin. Bottles of 16 and 100.

References: 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (A 28) 1962. 2. Ivler, D., *et al.*: Abstracts, Third Interscience Conference Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stew G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Gr 1. W. B., *et al.*: Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postg Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Tho *19*:298, 1964. 9. May, J. R., *et al.*: Lancet *ii*:444 (Aug. 29) 1964. 10. Pi A.: Lancet *ii*:445 (Aug. 29) 1964.

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Hundreds of patrons were attracted to the booth which was attended alternately throughout the 12-hour day by Medical Assistant Members attired in sparkling white uniforms. Two thousand pamphlets on "How To Be a Good Patient," "Your Family Health Record," "Let's Use, Not ABUSE, Health Insurance," and "Facts About Mental Health" were distributed to the visitors.

Medical Record Librarians

Dr. Robert R. Baumann, dermatologist at the Monroe Clinic, was guest speaker at the regional meeting of the Wisconsin State Medical Record Librarian Association in October at St. Clare Hospital, Monroe.

Mrs. Edna Pihl, Fort Atkinson, presided over the business session in the absence of Sister M. Myra, Beaver Dam. Louise Hough, Stoughton, was secretary for the meeting. Hostess was Sister M. Clarella, R.N., medical record librarian at St. Clare Hospital. Members attended from Baraboo, Portage, Fort Atkinson, Madison, and Columbus.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met for dinner and a scientific program November 24 at the University Club of Milwaukee. *Dr. A. C. Kissling, Jr.*, reported on the First World Congress on the Cornea and *Dr. Richard O. Schultz*, chairman of the Department of Ophthalmology of Marquette University, spoke on the supject, "Corneal Ulcer."

Wisconsin Diabetes Association

PHYSICIAN DIRECTORS OF THE Wisconsin Diabetes Association cooperated in a program of "Nursing Care of Persons with Diabetes Mellitus" conducted in November under the sponsorship of the University of Wisconsin-Milwaukee, Department of Nursing.

Pictured left to right are: Mrs. Agnes G. Jensen, R.N., Nursing Consultant, State Board of Health, Karl H. Beck, M.D., Milwaukee, John H. Esser, M.D., Milwaukee, and Patricia Shier, R.N., Assistant Supervisor, Visiting Nurse Association, Milwaukee.

Forty-three nurses attended the day long program. Doctor Esser, an internist, spoke on the medical aspects of diabetes. Doctor Beck, a pediatrician, discussed the treatment of the Young Diabetic.

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Wisconsin Ob-Gyn Society

Dr. John W. Greene, professor of obstetrics and gynecology at the University of Kentucky Medical School, was the featured speaker at the annual fall meeting of the Wisconsin Society of Obstetrics and Gynecology November 13 and 14 at Kenosha. St. Catherine's Hospital was the setting for the all-day scientific program. An open house for members was held the evening of the 13th at the home of *Dr.* and Mrs. *Walter C. Rattan.*

Rock County Medical Assistants

Plans for a Christmas party to be held in Janesville at La Pod's on December 8 were made by Rock County Medical Assistants November 10 when they met at the Hilton Hotel in Beloit. *Dr. G. F. Woodington,* surgeon at the Beloit Clinic, was speaker for the meeting, on the topic, "Cancer of the Lung."

* * *

IN THE FIRST 11 months of last year, only 15 new drugs were brought to market, according to the Pharmaceutical Manufacturers Association. This, says PMA, is the smallest number since 1955.

St. Mary's Hospital, Milwaukee, Opens Cancer Diagnostic, Treatment Center

Saint Mary's Hospital, Milwaukee, on January 25 opened a Cancer Diagnostic and Treatment Center under the direction of *Dr. John D. Hurley,* associate professor of surgery and cancer coordinator at Marquette University School of Medicine, and liaison fellow for the cancer programs of the American College of Surgeons for the State of Wisconsin.

Announcement of the center was made in a joint statement by Sister Josephine, hospital administrator, and *Dr. M. C. F. Lindert,* president of its medical staff, at the staff's annual meeting.

The hospital's commitment to a total cancer program began in 1961 with the institution of a radiotherapy service under the direction of *Dr. Anthony J. Grueninger.* It continued with the establishment, in 1963, of a radioisotope laboratory directed by *Dr. Philip P. Ruetz.* The hospital also maintains a cancer registry and is a cancer program hospital approved by the American College of Surgeons.

Doctor Hurley and his associate, *Dr. Joseph A. Manago,* are moving their offices and laboratory to Saint Mary's. Doctor Hurley's program will be coordinated with the intern and resident training programs as well as those of the schools of nursing and medical and x-ray technology.

Kenosha County Medical Assistants

Photo courtesy KENOSHA NEWS

NEW OFFICERS of the Kenosha County Medical Assistants Society were installed January 20 in a ceremony following dinner at Kroks Restourant, Kenosha. Pictured (lower left to right) are Mrs. Kenneth Wood, outgoing president, and Mrs. Amber J. Kircher, installing officer and a past president, who are presenting the gavel to Mrs. John Hains, new president. Also taking part is Dr. R. G. Welsch, president of the Kenosha County Medical Society.

WAS YOUR MEDICAL ASSISTANT REPRESENTED?

To SMS:

Forty-seven members of the Wisconsin State Medical Assistants Society attended the AAMA Leadership Training Seminar on September 12, 1964, in Waukesha, which was conducted by Miss Alice Budny of Milwaukee, Wis. If reactions verbal and written, are criteria for measuring the success of this program, we are pleased to report that the participants considered it very beneficial. Responses to group participation were animated and precipitated interesting discussions relating to local chapter problems, such as obtaining and retaining members, increasing attendance at monthly meetings, getting members to accept an office or chairmanship, how to improve public relations, etc. A great deal of enthusiasm was generated among the members present. A need for an annual Leadership Training Seminar, both on a State and Local level, was the consensus of the group.

Thanks again for your splendid cooperation in publishing the articles submitted by the members of our Organization.

Miss Alice L. Roelse
Chairman, Public Relations
WSMAS

Observes 100th Birthday

Early December of 1964 brought two amazing anniversaries to Dr. Edward A. Loomis, retired Janesville physician. December 1, he observed his 100th birthday, and December 5, he and Mrs. Loomis celebrated their 75th wedding anniversary. Plans for a community celebration honoring the couple had to be canceled because Doctor Loomis is bedridden with arthritis. Otherwise his general health is "amazingly good."

He is listed by the American Medical Association as one of 26 living American physicians who have reached the age of 99 or more.

Doctor Loomis enrolled in Milwaukee Medical School more than 70 years ago. He practiced briefly at Union Grove, and for 10 years at Emerald Grove, before locating in 1911 at Janesville, where he practiced for more than 40 years before retiring.

Dr. Andrews Honored on His Retirement

Honoring *Dr. W. C. Andrews* on his retirement after 36 years of serving the Frederic community, more than 150 people gathered for a dinner party January 11 at the Frederic High School. *Dr. R. M. Moore*, Frederic, acted as master of ceremonies for a brief program at which speakers included Wallace Early, Frederic's mayor; Frank Witucki, representing the hospital board; *Dr. W. A. Fischer*, representing the Frederic Clinic; *Dr. Otis Simenstad*, Osceola, speaking as a friend and associate of early days in the Polk County Medical Society; Glenn Waldschmidt, Rothschild, representing the State Medical Society of Wisconsin, and Calvin Johnson, who represented the sponsoring organization, the Frederic Association of Commerce.

Dr. W. C. Andrews
Photo courtesy FREDERIC INTER-COUNTY LEADER

Doctor Andrews came to Frederic in July of 1928 to be associated with the Arveson-Diamond Clinic, and later to enter into partnership with the late Dr. R. G. Arveson. Though his special training had been in the field of internal medicine and cardiology, he soon became known as "the baby doctor." He estimates that during his years in Frederic he has delivered nearly 3,000 babies, in many cases delivering the infants of two generations in the same family.

Diabetes Lay Society

Dr. Robert E. Johnston, Green Bay, spoke on "Care of Eves of Diabetic" at the first meeting of the season of the Northeastern Wisconsin Diabetes Lay Society October 28 at the Green Bay YMCA. A film, "Diabetes—What You Don't Know Can Hurt You," was shown.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Dr. Schroeder Locates in Milwaukee

Dr. Kenneth P. Schroeder has opened an office for general practice in Milwaukee, his home town. Prior to locating there, he took postgraduate training in internal medicine for three months at Milwaukee Hospital and before that, spent a year as a resident in internal medicine at University Hospitals, Madison.

Dr. Gandhi Joins Marshfield Clinic

The staff of the Marshfield Clinic now stands at 57 with the addition in November 1964 of Dr. Kishin V. Gandhi, a native of India who came to this country in 1954. Doctor Gandhi completed graduate work in otorhinolaryngology in 1957 at Northwestern University Medical School, Evanston, Ill.

Dr. Erdlitz at Mauston

Dr. F. J. Erdlitz, most recently at Mauston, is now at Rio where he has taken over the office of the late Dr. William A. Langmack.

Dr. Preizler at Washington Conference

Dr. Josef Preizler, Madison, director of the State Board of Health's Division of Mobile Unit Case Finding, participated in the Second National Conference on Cardiovascular Diseases November 22–24, 1964, in Washington, D.C.

Dr. Cooper Resigns

After holding the position for three years, *Dr. H. G. Cooper* has resigned as head of the Outagamie County Community Guidance Center at Appleton.

Dr. Thomas at Sacred Heart

Dr. Preston W. Thomas has been appointed director of Sacred Heart Sanitarium succeeding *Dr. John F. Wyman*, who retired January 1 after serving for 35 years on the medical staff of the sanitarium.

Dr. Mueller Plymouth Hospital Head

Dr. Joseph F. Mueller assumed duties as president of the medical staff of the Plymouth Hospital on January 5. *Dr. Harris A. Weisse* was elected secretary-treasurer for the coming year.

Dr. Cash Elected to Board

Dr. Isadore I. Cash, Milwaukee, was elected to the board of governors of the American College of Gastroenterology at its annual meeting October 18, 1964, at The Roosevelt, New York City.

Drs. John Walsch, Robert Henkle, and William Corcoran

New Walsh & Henkle Clinic

November 16 was the official opening date for the new Walsh & Henkle Medical Group in Port Washington. Owners of the new clinic are *Dr. John F. Walsh*, senior partner in the group, and two other general practitioners, *Drs. Robert F. Henkle* and *William A. Corcoran, Jr.*

Dr. Lipscomb Reelected

Dr. Thomas C. Lipscomb, Wauwatosa, has been reelected president of the medical staff of St. Anthony Hospital, Milwaukee. Also reelected were two Milwaukee physicians, *Drs. John P. Fetherston, Jr.*, vice-president, and *William E. Feierstein*, secretary-treasurer.

Dr. Walter Attacks Quacks

Dr. William Walter, Eau Claire surgeon, told Menomonie Rotarians December 23, 1964, how "health quacks" are bilking the public out of at least $800,000,000 yearly.

Doctor Walter named "nutritional nonsense" as No. 1 on the gyp parade, adding to it such misrepresented drugs as "glorified aspirins," which an Arthritis and Rheumatism Foundation survey found are perhaps the greatest money-wasters, and the fake cancer cures which extort some $50,000,000 a year from cancer victims.

Dr. Kass Joins Midelfart Clinic

Since January 6, *Dr. Robert M. Kass* has been a member of the staff of the Midelfart Clinic, Eau Claire. Certified by the American Board of Pediatrics, Doctor Kass practiced that specialty for several years at Wausau.

Dr. Healy Granted Fellowship

Dr. William G. Healy, Madison physician and surgeon, has left for a three-year residency at the Medical School of the University of Iowa, Iowa City. He has received a fellowship from the National Institute of Mental Health for the study of psychiatry.

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THAT SAILFISH in the background was caught several years ago off the Florida coast, but the future should bring a chance to hook another for Dr. R. H. Goedecke, for the West Salem physician has retired, and with his wife and son is planning to spend part of the year in Florida, enjoying fishing and other sports.

Dr. Goedecke Retires

After 35 years in the medical profession, *Dr. R. H. Goedecke* retired from active practice Nov. 30, 1964. He had been engaged in general practice in West Salem since 1929, when he became associated with *Dr. Guy F. Wakefield.*

Recalling the changes in medicine since that time, Doctor Goedecke says that when he first started practicing he could get along nicely with about six items: morphine, aspirin, castor oil, phenobarbital, atropine, and a hot water bottle. Then, too, a practice was carried on mostly in homes of patients, and most babies were born at home, which usually meant sitting up all night "in one of those hard kitchen chairs." The approximately 4,000 babies he has delivered include the largest twins and the only living triplets born at St. Ann's Hospital, La Crosse.

Doctor Goedecke has been president of the La Crosse County Medical Society, teacher of pediatrics at St. Francis School of Nursing, La Crosse, and president of the La Crosse Hospital.

Dr. Kundel Locates in Rice Lake

Dr. Robert Kundel joined the staff of St. Joseph's Hospital, Rice Lake, last fall as a radiologist. He received his medical degree from the University of Iowa in 1956, interned at the county hospital in Des Moines, was in general practice for three years in Ely, Minn., and in 1960 went to the University of Minnesota for his residency in radiology.

Dr. Samp Tours for Cancer Crusade

Dr. Robert J. Samp, assistant professor of surgery, division of clinical oncology, at the University of Wisconsin, Madison, spent several days early in January touring the western half of the United States for the National Cancer Crusade.

Dr. Shapiro Retires from Reserve

Dr. Herman H. Shapiro retired in December 1964 after nearly a quarter century in the Army Reserve, 16 years of that time spent as commanding officer (colonel) of the 44th General Hospital, Madison area U.S. Army Reserve hospital unit. A farewell dinner in his honor was held in December at Welch's Embers, Madison. Doctor Shapiro is a clinical professor of medicine at the University of Wisconsin Medical School, Madison.

TRAFFIC SAFETY STAMP RESULT OF LONG CAMPAIGN BY THE STATE MEDICAL SOCIETY

Efforts of the State Medical Society have culminated in the scheduled issuance of a 5-cent traffic safety commemorative stamp to be printed sometime in 1965. Approval of the stamp was announced in December by Postmaster General John A. Gronouski in a letter to Representative Melvin R. Laird.

Some 15 commemorative stamps are issued each year by the Postmaster's Department, which receives approximately 250 to 300 requests for commemorative issuances each year and has a backlog of over 2,000 to consider.

Nevertheless, in 1959 the Council of the State Medical Society passed a resolution calling for a commemorative stamp to be issued for five consecutive years which would point to the need for traffic safety on highways throughout the nation. It was further suggested in the resolution that the first date of issuance be made in state capitals throughout the nation.

In support of the Society's measure, a joint resolution was passed in the Wisconsin State Legislature and the Wisconsin congressional delegation was alerted. Although the project had considerable support, it took five years to gain approval.

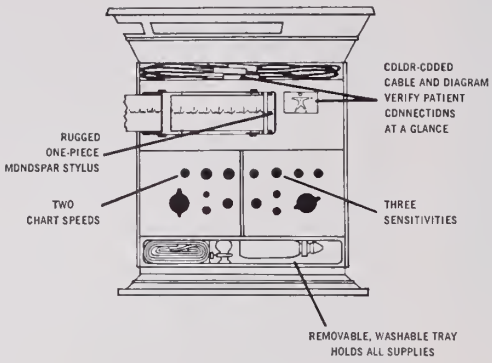
Determination of the date and place of the first day's sale, an event that causes considerable attention among the approximately 20-million stamp collectors in the nation, has not yet been made.

In a letter to Postmaster Gronouski, the Society's secretary, C. H. Crownhart, pointed out, "It would be my hope in light of the record of activity that Wisconsin could be chosen as the state for first date of issue, and because of the activity not alone by the State Medical Society but the Legislature and other bodies housed in Madison, that Madison will be chosen as the place of issuance."

Wisconsin sustained, last year, a record number of fatalities in traffic accidents.

The last traffic safety stamp issued was in 1952 on the occasion of the American Automobile Association's 50th Anniversary.

500 ViSO



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*Loughlin, E. H. et al.: Antibiot. Med. 7 739, Dec., 1960.

Condition	No. of Patients	No. Responded to Signemycin
Amebiasis	237	222
Cholecystitis and cholangitis	105	97
Enteritis	41	31
Peritonitis	15	14
Various, including pancreatitis, appendicitis and colitis	27	23
Totals	425	387 (91.1%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Brief Summary and Bibliography follow.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 16, 1964

NEW MEMBERS

Don P. Baumblatt, 834 Main Street, Racine.
Richard E. Bilbo, 425 East Wisconsin Avenue, Milwaukee.
Richard B. Bourne, 208 East Wisconsin Avenue, Milwaukee.
Dwight H. Brown, 4235 North 51st Boulevard, Milwaukee.
Brian T. Coffey, 701 William Street, Racine.
Daniel P. Collins, 8901 West Lincoln Avenue, Milwaukee.
Kurt G. Dehne, 11810 West Diane Drive, Milwaukee.
Escolastico D. Deocampo, St. Luke's Hospital, Racine.
Charles F. Dungar, 506 East Longview Drive, Appleton.
Stanley M. Englander, 3760 North Bay Road, Racine.
Frederick R. Entwistle, 324 East Wisconsin Avenue, Milwaukee.
Norman M. Fisk, 1672 South 9th Street, Milwaukee.
James E. Garman, 2200 West Kilbourn Avenue, Milwaukee.
Henry M. Goldberg, 3531 West Burleigh Street, Milwaukee.
Ashahel J. Hockett, 607 Pine Street, Mosinee.
Kenneth K. Hoelscher, 7127 North Green Bay Avenue, Milwaukee.
Marsh H. Holt, 8700 West Wisconsin Avenue, Milwaukee.
Clarence W. Jordahl, Jr., 2200 West Kilbourn Avenue, Milwaukee.
Earl B. Kitzerow, 1607 East Frances Street, Appleton.
Douglas D. Klink, 324 East Wisconsin Avenue, Milwaukee.
Joseph A. Manago, 8700 West Wisconsin Avenue, Milwaukee.
Marcial Martinez–Larre, 3931 North Bay Drive, Racine.
Gisela M. Meloy, 4098 North Lake Drive, Milwaukee.
Terryl B. Montgomery, 7635 West Bluemound Road, Milwaukee.
Harold R. Onkst, 8700 West Wisconsin Avenue, Milwaukee.
Nicholas L. Owen, 1600 North 116th Street, Milwaukee.
John G. Rawland, 5417 North 60th Street, Milwaukee.
Robert F. Schilling, 1300 University Avenue, Madison.
Richard O. Schultz, 8700 West Wisconsin Avenue, Milwaukee.
Margaret J. Seay, 301 Troy Drive, Madison.
Kwoh Cheng Sun, Siren Memorial Hospital, Siren.
Walter R. Sundstrom, 1912 Atwood Avenue, Madison.
Robert C. Tabet, 4602 South Packard Avenue, Cudahy.
Carl B. Weston, 1 South Pinckney Street, Madison.
Joseph L. Wind, 8901 West Lincoln Avenue, West Allis.

REINSTATED

Edward C. Ferguson, 300 Spring Street, Fox Lake.

CHANGES OF ADDRESS

John F. Alstadt, Milwaukee, to 10691 West Parnell Avenue, Hales Corners.
Rudolph Balzer, 9531 South Howell Avenue, Milwaukee.
Kenneth A. Bittle, 26802 Highland Avenue, Patton, Calif.
Roland C. Brown, 3853 North 55th Street, Milwaukee.
William L. Cochrane, Beloit, to West School Street, Three Lakes.
Albert M. Cohen, 6815 West Capitol Drive, Milwaukee.
R. Sanford Cook, 1214 Homestead, Beaver Dam.
Leslie Fai, 6750 Sheridan Road, Kenosha.
L. E. Fazen, Sr., 900 Lake Avenue, Racine.
Edwin H. Federman, Montello, to Princeton.
Jerome A. Goodman, 7712 West Burleigh Street, Milwaukee.
Margaret M. Hanauer, Milwaukee, to 1040 Lower Ridgeway, Elm Grove.
Walter J. Jones, 2401 Main Street, La Crosse.
Thomas A. Judge, 1609 North Prospect Avenue, Milwaukee.
William W. Kah, 7712 West Burleigh Street, Milwaukee.
C. J. Kienzle, 1107 West Oklahoma Avenue, Milwaukee.
Robert E. Klingbeil, Waukesha, to 12750 Green Meadow Place, Elm Grove.
John F. Koppa, 110 East Main Street, Madison.
W. L. Krygier, 1107 West Oklahoma Avenue, Milwaukee.
George Light, Milwaukee, to University of Iowa, Childrens Hospital, Iowa City, Iowa.
Robert E. McMahon, Wisconsin State University, La Crosse.
E. J. Miller, 436 East Longview, Appleton.
M. G. Peterman, Milwaukee, to Department of Health, Education and Welfare, 200 C. Street, Washington, D.C.
C. A. Rothe, Omaha, Neb., to Box 240, Warren, Pa.
Marvin E. Royce, Honokaa, Hawaii, to 825 Andrade Avenue, Calexico, Calif.
Paul W. Ryan, 4610 North Marlborough Drive, Milwaukee.
Cleon L. Schultz, Spokane, Wash., to S. 113 Kentucky Avenue, Roswell, N. M.
William Stoll, 238 Little Road, Green Bay.
L. H. Stone, 2121 Bowen Street, Oshkosh.
George H. Thomson, 2031 Riverside Drive, Beloit.
Loren J. Yount, Hales Corners, to 2834 South 133rd Street, New Berlin.

REMOVED FROM MEMBERSHIP

Roland E. Berry, Milwaukee County, transferred to Michigan.
G. H. Burnett, Dane County, resigned.
Robert C. Buxbaum, Dane County, resigned.
William A. Cook, Waukesha County, resigned.
J. B. Leith Hartman, Waukesha County, transferred to Louisiana.
Joseph P. LaFlare, Brown County, transferred to New York.
Pearl L. Sanders, Dane County, per county secretary.

DEATHS

Albert J. Randall, Kenosha County, October 8, 1964.
Charles Merulla, non-member, October 12, 1964.
George H. Chesky, non-member, October 15, 1964.
William D. Stovall, Jr., non-member, October 18, 1964.

Of 748 patients with confirmed G.U. infections... 684 or 91.4% were treated successfully with Signemycin®

Note:
The efficacy of Signemycin was shown in a study of nongonococcal urethritis involving over 1600 patients.* A comparison of the cure rates of sixteen antibiotic and chemotherapeutic agents revealed that Signemycin had the highest incidence of successful response. One hundred and six patients were treated, of which 82 were followed, with cures in 70.

*Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962.

Condition	No. of Patients	No. Responded to Signemycin
Cystitis	29	25
Pyonephritis	30	28
Pyelocystitis	119	112
Prostatitis	14	13
Gonorrhea	66	64
Lymphogranuloma venereum	96	96
Syphilis	31	31
Urethritis, nonspecific	149	131
Various, including infections seen with impaired urinary flow or lithiasis	214	184
Totals	748	684 (91.4%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Brief Summary and Bibliography follow.

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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the wisconsin medical journal

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Volkmann's Contracture of the Lower Extremities

A Report of 14 Cases Arising in Children

By J. G. NOBLE, M.D., F.R.C.S. (C), F.I.C.S., Monroe, Wisconsin

■ VOLKMANN'S CONTRACTURE is the name given to a progressive, rapidly developing contracture of muscle following trauma.

Richard von Volkmann published an account of this disorder in 1872. At this time he attributed the contractures to traumatic myositis, and recognized the fact that this was not the same disorder as contracture following neurological paralysis. Later he published further cases and was the first to recognize that the essential cause of the contracture was ischemia of muscle. He believed that tight bandaging and faulty splinting were the usual cause of the vascular obstruction. The current view is that the ischemia is due to partial occlusion of the main arterial inflow with concurrent spasm in the collateral vessels.[1]

In the upper extremity, Volkmann's contracture is a well recognized complication of supracondylar fracture of the humerus, to posterior dislocation of the elbow, and to a lesser extent to severe crushing injuries of the forearm and of fractures of the radius and ulna. In the lower extremity the condition is less common and is probably less well recognized.

In the years 1931 to 1947, a review of 18 cases of Volkmann's contracture of the lower extremity was reported by Thomson.[2] He remarked that skin traction used in the closed treatment of fracture of the shaft of the femur was a potential cause of Volkmann's ischemia. The treatment of fracture of the shaft of the femur in this particular hospital* usually consists of gallows traction for children under the age of 3 years. (Maximal body weight for gallows traction is 30 lb.) Older children are usually treated by the use of a Thomas splint and skin traction. This traction is continued until callus is evident, when a hip spica is usually applied.

Experimental work by Mustard and Simmons[3] has demonstrated that traction after experimental division of the femur can produce generalized distal arteriospasm. This was demonstrated by arteriography.

This review of cases was stimulated by the following factors:

(1) Cases of Volkmann's contracture continue to arise in this hospital as a complication of treatment of fractured femur.

(2) Established cases of Volkmann's contracture referred to the hospital have been unrecognized and sent for psychiatric opinion with admission diag-

---

Doctor Noble's current address is: 233 Medical Arts Building, Saskatoon, Sask., Canada.

* Hospital for Sick Children, Toronto, Ontario, Canada, where Doctor Noble was a Resident in Orthopedics.

noses such as hysteria, possible spinal cord tumor, and poor motivation for recovery following fracture.

Thus the initial episode leading to the Volkmann's contracture is probably passing unrecognized and the established picture, especially if mild, appears to be a source of diagnostic confusion.

Review of approximately 500 cases of fracture of the femur was undertaken. The period under review was from 1950 to 1954 and 489 such cases were reviewed. Seven cases of Volkmann's contracture arose in this group, as a sequel to fracture of the femur. During the same time interval an additional 7 cases of Volkmann's contracture were referred to the hospital. Four were associated with a fracture of the femur; one was a late result of a fracture of the tibia; one was complicating a fractured pelvis and a crushing injury of the right leg, and one was complicating a soft tissue injury to the left leg.

Case Reports. The first series consists of those cases of Volkmann's contracture arising primarily at this hospital.

Case 1. A boy, 14 years of age, who was hit by an automobile, sustained a fracture of the right femur at the junction of the upper and middle thirds. There was no other significant injury. The fracture was treated with skin traction and a Thomas splint. Ten hours after the application of traction, severe pain was noted in the calf, and passive dorsiflexion of the right ankle was extremely painful. Sensation was noted to be normal at this time, but the posterior tibial pulse was absent. Fourteen hours after the establishment of traction, a hard plaque was noted in the skin over the calf. The bandages had been released when the pain was first noted, and the traction was reduced when the hard plaque was noted. No improvement occurred. Eighteen hours after traction had been set up, a spinal anesthetic was given, the traction removed, and a Kirschner wire drilled through the os calcis to provide skeletal traction. The fractured femur in this child healed uneventfully, and he went on to full recovery with no residual paralysis or sensory deficit.

Case 2. This was a boy aged 4 years who fell and sustained a spiral fracture of the midshaft of his right femur. He was treated with skin traction and a Thomas splint. Two days later the foot was noted to be anesthetic and the calf muscles were stony hard. Under spinal anesthesia a Kirchner wire was inserted through the os calcis and traction maintained. The child subsequently developed severe atrophy of the right calf with permanent weakness and equinovarus deformity. He required subsequent surgery consisting of tendo achillis lengthening, tendon transfers, metatarsal osteotomies, and a soft tissue release of the foot; but in spite of these procedures he had considerable permanent disability.

Fig. 1—Overhead traction with pulleys and weights.

Case 3. This was an 11-year-old boy who fell and fractured the midshaft of his left femur. He, too, was treated with skin traction and a Thomas splint. Five days later he developed severe pain in the left calf and within a few hours a Kirschner wire was inserted through the os calcis under spinal anesthesia. He developed some superficial necrosis of the skin over the calf but eventually made a full recovery and had no residual disability.

Case 4. This was a 10-year-old boy who fell on ice and fractured the middle third of his left femur. He was treated with skin traction and a Thomas splint. Twenty-four hours later the foot was noted to be dusky. The calf was painful at this time and "stocking" anesthesia as far proximal as the knee was noted. Kirschner wire was used to provide skeletal traction through the os calcis. This was inserted under spinal anesthesia. Two subsequent spinal anesthetics were used in an attempt to abolish vascular spasm in extremity but these were ineffectual and the boy finally developed severe residual paralysis with the characteristic equinovarus deformity of the left foot. Later he required a triple arthrodesis.

Case 5. This was a 13-year-old girl who fell on a sheet of ice and sustained a spiral fracture of the shaft of the left femur. A splint was applied as a first aid measure, and then she was admitted to the hospital, at which time she was found to have normal pulses and sensation in the left foot. She was immobilized in a Thomas splint using skin traction. The day following admission she had impaired sensation of the left foot with severe pain in the left calf. Passive dorsiflexion of the left ankle also was very painful. The bandages were released immediately. The next day the foot was pulseless, and paralysis of the calf was already present. Blisters 3 cm in diameter were present on the calf. Two spinal anesthetics given at this stage produced no circulatory improvement. Open reduction of the fracture of the femur was performed. The fracture was reduced and reduction maintained with a bone plate and screws. The femoral artery was visualized during this procedure and was noted to be stringlike. This child also developed permanent paralysis and required corrective surgery.

Case 6. This was a 13-year-old boy who fell 20 feet, sustaining a fracture of the proximal third of his right femur and a fracture of the scapula on the same side. He also was treated with skin traction and a Thomas splint. Six days after injury his right foot was observed to be swollen. Eight days after injury, without treatment in the interim, he was noted to have a foot drop. A spinal anesthetic was given at this time and a Kirschner wire inserted through the os calcis for traction. His fractures healed but he was left with the residual wasting and sensory deficit over the heel. With intensive physiotherapy he improved; and 18 months later he had normal function in the extremity, although he still had some calf-muscle wasting.

Case 7. This was an 11-year-old boy who fell from a bicycle and sustained a fracture of the shaft of the left femur. Three days after application of skin traction and a Thomas splint, his left foot was noted to be swollen and blue. Impending Volkmann's contracture was diagnosed and a spinal

Fig. 2—Fixed traction with Thomas splint.

anesthetic was given immediately. A Kirschner wire was inserted through the os calcis for skeletal traction. His fracture united uneventfully, and he developed no sensory deficit and little muscle wasting.

The following cases of established Volkmann's contracture were referred to this same hospital.

Case 8. A 4-year old girl sustained fractures of the left femur and the right tibia and fibula in an automobile accident. The fractured femur was treated in another hospital by reduction under general anesthesia. A hip spica cast was applied immediately. Three months later when the cast was removed the girl was referred to this hospital because of large deep ulcers on both legs as well as complete bilateral paralysis below the knees. The right tibia was not united. She subsequently required much corrective surgery and was left with considerable residual disability in both lower extremities.

Case 9. A 6-year-old girl who was hit by a truck sustained severe injuries including a fractured skull, a compound fracture of the right femur, and cerebral concussion. She was unconscious for two weeks following the injury and had a transient left-sided hemiparesis. The fractured femur was treated by manipulative reduction and immediate application of a plaster spica. On removal of this cast a fixed equinovarus deformity of the right foot was noted. The patient had residual weakness in the calf and in the peronei, and permanent anesthesia of the foot.

Case 10. A 7-year-old boy had suffered a fractured lower third of the right tibia. He was treated by manipulation under anesthetic and plaster cast. When seen two months later at this hospital, he had permanent paralysis of the calf. He subsequently required corrective surgery and had considerable residual disability.

Case 11. A 5-year-old girl who was involved in a car accident was unconscious for 48 hours. She sustained a fracture of the upper third of the shaft of the left femur and was treated by gallows traction. Two days after the establishment of traction, the right foot was noted to be blue and when the child recovered consciousness she was unable to move the right foot. The overhead traction was removed at this stage and the left leg immobilized in a Thomas splint. The child subsequently developed an equinovarus deformity of the *right* foot. This extremity was not injured in the accident.

Fig. 3—Fixed overhead traction.

Case 12. A 3-year-old-girl who was involved in a car accident sustained a fracture of the left femur with considerable bruising of the left leg. The fractured femur was treated by manipulation and immediate application of a hip spica. When this was removed eight weeks later, a large deep ulcer was present on the dorsum of the foot and a fixed equinovarus deformity of the left foot was present. The girl subsequently required pedicle grafts and corrective surgery, and had serious residual disability.

Case 13. This was a 7-year-old boy who sustained a fracture of the pelvis and a crushing injury of the right leg. He was treated by bed rest in another hospital. When referred to this hospital four months later, he had wasting of the right calf and a fixed equinovarus deformity of the right ankle with absent peripheral pulses and fibrosis of the muscles in the calf and the anterior com-

partment of the right leg. He had considerable residual disability and required corrective surgery.

Case 14. This was an 8-year-old girl who fell and injured her left flank. She was treated elsewhere and was referred to the hospital 14 days later. At this time an intravenous pyelogram showed non-function of the left kidney. The girl subsequently had a large hematoma drained from the left flank. She developed severe postoperative shock and at this time had absent peripheral pulses and anesthesia of the left foot and leg. Sympathetic blocks were ineffective, and she finally developed a fixed equinovarus deformity of this foot.

Comments. In all of the 7 cases where Volkmann's ischemia contracture arose during the course of treatment in this hospital, the primary injury was fracture of the femur. In no case was the fracture in the supracondylar area of the femur where direct trauma to the main vessels was a likely cause of direct vascular injury. In no case was evidence of impending Volkmann's contracture present prior to the establishment of traction. This complication arose 10 hours after the establishment of traction in Case 1 and at the other extreme the interval between injury and the complication was six days.

The interval between the first symptoms and the administration of a spinal anesthetic and the establishment of skeletal traction varied between an hour or a little more in Case 7 to two days at the other extreme. Four cases (2, 4, 5, and 6) had permanent paralysis. In all of these cases there was delay between the recognition of the early symptoms and the establishment of spinal anesthesia and the institution of skeletal traction. In Cases 1, 3, and 7, residual damage was avoided except that in Case 7 there was a little permanent atrophy of the calf muscles. Seven other patients in this series of 489 cases were noted to have calf pain after the establishment of skin traction. These cases were believed to be impending Volkmann's contracture and were all treated urgently. Spinal anesthesia was established as soon as possible and Kirschner wire traction used instead of skin traction. The skeletal traction was inserted through the os calcis in all cases. None of these eight patients developed any residual disability. In the established cases which were referred to the hospital, the first patient (Case 8) illustrates the risk of manipulative reduction of a displaced femoral fracture and immediate application of hip spica. This child developed a bilateral Volkmann's contracture.

Case 9 illustrates the same risk, plus an additional one. The early warning symptoms of spontaneous pain, pain on passive dorsiflexion of the foot, and the presence of anesthesia were absent because the child was unconscious. Likewise, the presence of a spica made a scrutiny of the peripheral pulses and the skin impossible. Case 11 illustrates the risk of using gallows traction in a child of 5 years of age. The ischemia in this case involved the uninjured limb.

Summary. The majority of cases of Volkmann's contracture of the lower extremity arose in this hospital as a complication of treatment of fracture of the femur. Eleven out of the 14 cases were of this type. There appears to be a risk of development of this serious complication when skin traction is used; and if gallows traction is employed, the uninjured limb may also be involved. According to Blount,[4] this complication is more likely to affect the uninjured limb than the injured one. It also appears inadvisable to use strong analgesics after the establishment of traction in children. They are not needed after the establishment of efficient traction, and are dangerous because they mask the calf pain which is the most reliable early sign of Volkmann's ischemic contracture. This complication arose six days after injury in one case, emphasizing the importance of careful examination of patients in traction for several days after injury.

The early use of spinal anesthesia to relieve vasospasm should be undertaken if the release of bandages and traction does not secure immediate improvement of severe calf pain. Brower[5] states that muscle ischemia will be irreversible within six to eight hours and recommends that if release of bandages does not secure improvement within two hours that more definitive action should be taken. In 7 impending cases of Volkmann's ischemic contracture where spinal anesthesia was used urgently and skeletal traction established, there was no progression in the clinical picture and none of these patients developed residual disability.

In the 7 cases where the Volkmann's contracture was not aborted, 2 had no residual

defects and one had a minimal atrophy of the calf. The use of Kirschner wire traction through the os calcis enables the fracture to be controlled adequately, and there is no possibility of constriction of the circulation or pressure on the skin; likewise, the peripheral pulses and the condition of the skin are available for examination. In the one case where spinal anesthesia was used after the establishment of the contracture, no improvement resulted. In no case in this series was the deep fascia of the leg opened.

Conclusions. 1. Volkmann's contracture of the lower extremities still remains of serious significance; and in spite of the adoption in this hospital of a relatively safe method of treatment of fractures of the femur and general awareness of the importance of this complication, it still continues to be seen at the same rate as in the years 1931 to 1947.

2. Once the ischemia of muscle is established, there is no effective treatment which will prevent serious residual disability.

3. When the early signs and symptoms of Volkmann's ischemia arise, decisive action must be taken immediately. The unreliability of the quality of the peripheral pulse and peripheral skin color has been stressed by many authors. The presence of a severe claudication-like pain in the calf appears to be the most reliable symptom. The importance of avoiding narcotics, which may mask this early symptom, is stressed.

4. It appears that closed manipulation and plaster cast fixation in the treatment of displaced fractures of the femur are likely to cause Volkmann's ischemic contracture, and the danger of this type of treatment in unconscious patients is stressed.

5. The use of Bryant-type gallows traction for children over 30 lb. appears to be dangerous; where this was used in a 5-year-old-child, the patient developed a severe Volkmann's contracture. The need for careful supervision of patients in skin traction is once again stressed.

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The Painful Hip

By OWEN E. MILLER, M.D., Waukesha, Wisconsin
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■ TREATMENT OF THE painful hip in the adult is a modern orthopedic challenge. Until a generation ago the most effective therapy available was the empirical use of canes or crutches. The layman and the physician knew that weight bearing was reduced and the pain relieved. The cane has withstood the demands of time. The principles of surgical reconstruction now available are designed to restore near normal function to the disabled hip, whatever its etiology.

The etiologic factors in the painful hip are varied. Disease processes causing a painful hip are:

1. Congenital or developmental
   (a) The dysplastic or congenitally dislocated hip,
   (b) Slipped capital epiphysis,
   (c) Aseptic necrosis of the capital femoral epiphysis of childhood;
2. The arthritides
   (a) Infectious-pyogenic, tuberculous, luetic fungus,
   (b) Traumatic,
   (c) Degenerative (including osteoarthritis),
   (d) Systemic (including rheumatoid arthritis);
3. Aseptic necrosis of the adult femoral head
   (a) Idiopathic,
   (b) Caisson disease,
   (c) Effects of corticosteroids.

As noted, the etiologic factors causing a painful hip are varied. However, from a clinical, roentgenologic, and often a pathologic point of view, the end result, as far as the hip is concerned, is similar. The hip may be injured or altered in a variety of ways, but its response to such factors is less varied. In general there appear to be two responses. In the response most frequently observed the hip reacts by overproduction of peripheral bone at the joint margins and sclerosis within the contiguous surfaces of the joint. The other pathologic response appears to be a "melting away," an actual loss of bone tissue at the joint, as noted in rheumatoid arthritis.

Therapy of the painful hip falls into two broad categories: (1) therapy of the systemic disease process itself, such as the proper medical therapy for rheumatoid arthritis, and (2) therapy aimed at the mechanical reduction of weight-bearing at the affected hip. These are: (1) weight reduction, (2) use of a cane in the opposite hand, (3) judicious short rest periods, and (4) an intelligent hip exercise program to maintain muscle power and function and to reduce the effects of fatigue.

In many hip problems, an intelligent combination of these categories of therapy will maintain, for a long period, a functioning, comfortable hip.

Surgical therapy for the painful hip should be considered when the patient is not making satisfactory progress on a nonoperative program. There are four basic hip reconstructive procedures: arthrodesis, prosthetic replacement, osteotomy of the femur, and cup arthroplasty—the operation emphasized in this study. The procedures are in a sense complementary and extend the possibilities of surgical therapy. Each has a different concept. It is imperative to remember that with none of these procedures do we attain a normal hip but, with each, significant increase in function may be attained.

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Figure 1

Figure 2

Figure 3

Arthrodesis has its greatest merit in the young individual who has to perform demanding physical labor. Hip motion is sacrificed for pain relief; and when the surgery is well performed, the patient walks with a barely perceptible limp. This may be difficult to attain in a hip with marked loss of bone substance. If arthritis exists in the low back, an arthrodesis may aggravate it. Arthrodesis also may cause degenerative changes in the opposite hip.

Prosthetic replacement is a procedure of great promise. Its greatest value appears to be where the involvement is mainly in the femoral head. How long the prosthesis will perform within the human body is still undetermined. If the prosthesis fails, recovery procedures are possible but tend to be difficult, and the ultimate functional results are usually less than desirable.

Osteotomy in the trochanteric area, usually with medial displacement of the distal femoral shaft, is a procedure of proven value; but it does not appear to be an operation to consider if the patient already has marked loss of motion with less than 60 degrees of flexion, or if there is marked loss of the heads as there may be in aseptic necrosis.

We consider cup arthroplasty the procedure of choice for surgical hip disease in the young and middle-aged groups. With cup arthroplasty we are constructing a new hip joint by refashioning the femoral head and the acetabulum and interposing a vitallium cup. Cup arthroplasty, with its versatility, may fit virtually any surgical hip problem in the younger age group.

The surgical techniques employed will not be dealt with in detail in this discussion. However, it should be pointed out that the cup is ordinarily inserted through an anterior muscle-splitting approach (Fig 1). The capsule of the hip joint is completely removed with the synovia (Fig 2), and a hip joint is reconstructed by removing the cartilage and subcondylar bone of both the femoral head and acetabulum (Fig 3). Postoperatively the patient is placed in balanced suspension for four to six weeks (Fig 4), and progressive active exercises are instituted. With the initiation of ambulation with crutches, a complete physiotherapy program is commenced with the aim of strengthening the muscles about the hip. Primarily, muscle-strengthening exercises are directed to the hip abductors, flexors, and extensors.

Case Reports. *Case 1.*—This was a 28-year-old white male laborer who apparently had Legg–Calve–Perthes disease in the right hip at the age of 6 years, leaving him with a flattened, enlarged femoral head partially subluxated out of the acetabulum. The hip became symptomatic when the patient was 26 years of age, and at the time of surgery he had

Figure 4

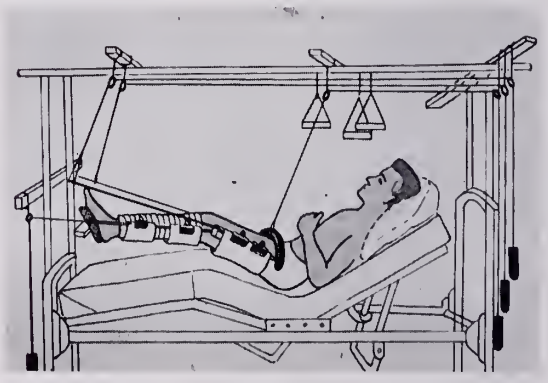

Figure 5

both day and night pain and was unable to walk because of hip discomfort.

Preoperative x-ray films (Fig 5) showed flattening of the femoral head and partial subluxation of the femoral head out of the acetabulum.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	90°	90°
Extension	10°	0
Abduction	35°	30°
Adduction	30°	30°
External rotation	50°	30°
Internal rotation	0	20°

Nineteen months after surgery the patient was employed as a mechanic and worked eight hours a day without discomfort. He had discarded his cane and stated that his hip bothered him only after prolonged exercise or excessive lifting (Fig 6).

Case 2.—This was a 49-year-old white woman who was believed to have had bilateral septic hips at the age of 16 years, with subsequent loss of motion and bilateral hip pain. Several years prior to her cup arthroplasty, she had a successful hip fusion on the right side. Following the fusion the left hip became increasingly painful; and during the year prior to the arthroplasty on the left hip, she complained of day and night pain.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	30°	70°
Extension	—20°	—15°
Abduction	0	25°
Adduction	0	20°
Internal rotation	—10°	10°
External rotation	20°	20°

One year after arthroplasty the patient had no night pain and only mild hip discomfort with prolonged walking or activity. Figure 7 shows the preoperative x-ray film of the involved hip, demonstrating obliteration of the cartilage space of the hip joint with hypertrophic spurring of the acetabulum and sclerosis and flattening of the femoral head. Figure 8 shows the cup one year postoperatively. It is riding in proper position in relation to the femoral neck and is satisfactorily seated in the acetabulum.

Case 3.—This was a 68-year-old white woman with advanced degenerative joint disease of the right hip,

Figure 6

Figure 7

Figure 8

which had been present for approximately 10 years, causing increasing pain and limitation of motion. Ambulation was exceedingly difficult and painful for the patient prior to the operation, and she was unable to sit or sleep comfortably because of hip pain.

Hip Motions	*Preoperative*	*Postoperative* (Fig 9)
Flexion	65°	90°
Extension	—40°	—10°
Internal rotation	20°	20°
External rotation	15°	25°
Abduction	0	25°
Adduction	20°	25°

Figure 9

Figure 10

Figure 11

Figure 9 shows a postoperative x-ray film of the involved hip with acceptable position of the femoral head and neck within the cup. The patient was satisfied with the pain relief that occurred postoperatively but had not cooperated in the muscle reeducation program. She had poor muscle power but had maintained pain relief in spite of the weak hip muscles. This patient is presently on two crutches and will likely remain so.

Case 4.—This was a 29-year-old white woman who had severe generalized rheumatoid arthritis and had been confined to a wheelchair for several years except for short excursions on crutches. The disease process was active and she had pain in all of the major joints. Her greatest problem was severe pain in the right hip, which prevented satisfactory marital relations (Fig 10).

Hip Motions	*Preoperative*	*Postoperative*
Flexion	50°	80°
Extension	10°	—15°
Abduction	—10°	20°
Adduction	10°	20°
Internal rotation	20°	0
External rotation	30°	35°

Cup arthroplasty was carried out one year ago. Relief of pain postoperatively was nearly complete. Because of the generalized rheumatoid disease, muscle reeducation and strengthening had not progressed as rapidly as in those cases with osteoarthritis, but this patient was probably the most satisfied of any in this series because of the relief of pain with all activities. Figure 11 shows the cup to be in satisfactory relationship to the acetabulum. The cup is riding in some valgus which adds to the stability of the hip.

Case 5.—This was a 59-year-old white woman who developed an idiopathic avascular necrosis approximately 10 years prior to cup arthroplasty. She had had increasing hip pain, both day and night. Her preoperative motions were near normal, except for a 40-degree hip flexion contracture.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	100°	100°
Extension	—40°	0
Abduction	20°	45°
Adduction	20°	30°
Internal rotation	10°	10°
External rotation	10°	10°

Cup arthroplasty was completed eight months ago with relief of the hip pain. This patient, also, has not attempted any muscle-strengthening exercises and, therefore, lacks stability that could be hers with additional effort. However, her postoperative motions are excellent as is her pain relief while on crutches.

Case 6.—This was a 43-year-old white man with Strümpell–Marie arthritis of the thoracic lumbar spine. He developed right hip pain approximately two years prior to surgery. The hip pain became increasingly severe and was associated with progressive limitation of motion. A hip flexor release (iliopsoas, sartorius, rectus femoris), failed to relieve his pain or increase the hip motion. The patient had a thoracic kyphosis of approximately 40 degrees and the spine was fused from T–1 to L–5. With the developing hip flexion contracture in the painful right hip, the patient was unable to fully extend it. He was, therefore, functionally fused from T–1 to the right knee. In order to stand with his weight on his right leg, the patient flexed 90 degrees and could not see in the direction he was walking. In order for him to stand with his head held forward, his right thigh had to be lifted from the ground

and held at approximately 45 degrees. This made his gait very difficult and he walked with a piston-type action, with his head rising and falling with each step.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	80°	80°
Extension	—45°	10°
Abduction	0	15°
Adduction	15°	10°
Internal rotation	0	10°
External rotation	0	10°

He is now nine months postarthroplasty and is walking independently without crutches or cane. His muscle-strengthening about the hip has been rapid, and his pain relief has been complete. His gait is greatly improved because of the restoration of motion in the involved hip, and he is functionally the most improved patient in this group.

Case 7.—This was a 47-year-old Indian woman who developed tuberculosis of the left hip at the age of 30 years, with subsequent destruction of the femoral head and acetabulum. Four years after onset of the disease an extra-articular fusion was attempted but was unsuccessful. Preoperative films showed the bone strut attached to the left iliac wing, with the destruction of the left hip and near complete absence of the left femoral head. The attempted fusion was successful in the left iliac wing, but it developed a nonunion in the region of the greater trochanter. The patient has had pain in the involved hip since the onset of the tuberculosis. Her limited motion and increasing day and night pain were the indications for cup arthroplasty which was performed four months ago.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	30°	70°
Extension	20°	—10°
Abduction	0	30°
Adduction	0	20°
Internal rotation	0	20°
External rotation	0	20°

Extensive reconstruction was necessary at surgery with removal of the bone graft, construction of an acetabulum, and preparation of the trochanteric area for fitting of the cup. The abductor muscles, which were rudimentary but nevertheless present, were transferred to the insertion of the vastus lateralis. Postoperative x-ray film showed the shaft arthroplasty with the cup seated well in the acetabulum. Two Kirschner wires were used superior to the cup to immobilize a portion of the acetabulum, which was loosened during the procedure but which was necessary for stability. Postoperatively, pain has been relieved and motion restored. The patient ambulates with a two-inch lift on the left shoe and has a gratifying return of muscle function about the hip.

Case 8.—This was a 28-year-old achondroplastic dwarf who had bilateral congenital dislocated hips. The hips became symptomatic at the age of 24 years, and the patient developed increasing pain and limitation of motion in both. His preoperative x-ray film (Fig 12) showed the bilateral hip dysplasia and distortion of the femoral heads and acetabuli. A cup arthroplasty, performed 18 months ago, brought about relief in the right hip with restoration of hip joint function. Six months ago a cup was placed in the left hip. This unfortunately became infected and the patient developed copious quantities of purulent drainage which cultured Staphylococcus aureus. At six weeks the patient had continuing drainage through an anterior sinus tract. A revision of the cup was then done with debridement of the entire area and insertion of a second cup (Fig 13). The patient has had relief of pain and increasing muscle strength on that side. He does have considerable residual weakness about both hips, but he is progressing satisfactorily with the rehabilitation program. He has had no further evidence of infection.

Case 9.—This was a 52-year-old Negro man who had sustained a fracture of the left hip four years before and developed an avascular necrosis of the femoral head. He had increasing pain and limited motion. An arthroplasty was performed six months ago.

Figure 12

Figure 13

Figure 14

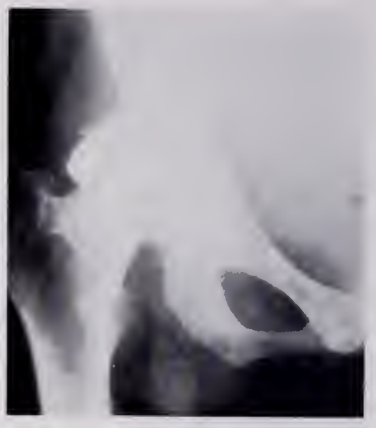

Figure 15

Hip Motions	*Preoperative*	*Postoperative*
Flexion	80°	90°
Extension	—40°	—10°
Abduction	0	20°
Adduction	10°	20°
Internal rotation	0	15°
External rotation	0	25°

Preoperatively, this patient presented a puzzling clinical picture of bilateral hip pain. X-ray films of the right hip showed it to be normal; but because of increasing stress placed on the normal hip, the patient had bilateral hip discomfort. A cup arthroplasty was performed six months ago. The patient is now relieved of day and night pain and walks without discomfort with one cane.

Case 10.—This was a 48-year-old Negro woman who sustained a comminuted fracture of the left acetabulum at the age of 45 years. The patient developed increasing pain and limited motion in the hip.

Hip Motions	*Preoperative*	*Postoperative*
Flexion	80°	90°
Extension	—20°	0
Abduction	10°	15°
Adduction	10°	15°
Internal rotation	0	15°
External rotation	40°	30°

Following cup arthroplasty four months ago, the patient has had complete relief from hip pain and is ambulatory with two crutches, with increasing hip muscle function.

Case 11. This was a 32-year-old white man with burned-out, severe, generalized, rheumatoid arthritis and ankylosis of the major joints. In addition to arthroplasty of an elbow and reconstructive procedures on the feet, the patient had cup arthroplasty on the right hip two months ago. Preoperatively there was no clinical motion in the right hip.

Hip Motions	*Postoperative*
Flexion	80°
Extension	—15°
Abduction	20°
Adduction	20°
Internal rotation	10°
External rotation	30°

Case 12.—This was a 32-year-old Negro woman who had an apparent septic hip joint at the age of 11 years, with increasing hip pain and limitation of motion during the five years preceding surgery. The hip was fixed in 25 degrees of adduction, and the patient complained of severe pain at the hip with weight-bearing (Fig 14).

Hip Motions	*Preoperative*	*Postoperative*
Flexion	65°	80°
Extension	—35°	—10°
Abduction	—25°	20°
Adduction	35°	20°
Internal rotation	20°	15°
External rotation	10°	20°

Now, six months postoperatively, the patient has occasional hip pain with excessive walking. She is slowly increasing her muscle function about the hip (Fig 15).

Comment. In this series of 14 cases, our greatest success has been in the young and middle-aged groups. Cases 3 and 5, however, are examples of cup arthroplasties done on elderly people. In our experience these people are not able to carry out the intensive and prolonged muscle reeducation program the cup arthroplasty requires for successful results. Although these people have not regained significant motion or been emancipated from crutches, they have been grateful for pain relief.

With the reservation of age, these case reports indicate the diversity of hip problems which have had surgical treatment. The longest follow-up is 19 months (case 1); the shortest, 2 months (case 11). The 14 cases may be grouped in the following manner: old fracture acetabulum, 2; old septic arthritis, 3; idiopathic degenerative arthritis, 2; old dysplastic hips, 3; rheumatoid arthritic hips, 3; and hip postoperative infection, 1.

In the dysplastic cases (1 and 8) there is demonstration of the possibility of constructing a new, deeper acetabulum. Case 1 indicates, at 19 months, an excellent functional result. In case 8, two cup arthroplasties were

performed for dysplastic hips. Following the second cup arthroplasty the patient developed a severe postoperative Staphylococcus aureus infection. Usually a postoperative infection in reconstructive hip surgery indicates total failure of the procedure. In this case the cup arthroplasty was revised six weeks after the original operation, with total excision of infectious granulation tissue and reinsertion of the cup. The wound healed per primam under appropriate antibiotic cover. No other reconstructive procedure at the hip allows such recovery. It is also possible to use cup arthroplasty following infectious complications of other hip reconstructions except that reconstruction of an osteotomy is technically difficult.

Three patients had cup arthroplasty for rheumatoid arthritis. In addition, each of the three had a total joint synovectomy, an important surgical consideration in rheumatoid arthritis. In the rheumatoid patient we do not anticipate as great an improvement in motion as in other groups. These patients are people with a serious systemic illness which seriously limits their ability to carry out a rigorous postoperative exercise program. However, they have had pain relief and motion gain significant enough to make them our most appreciative patients.

Seven patients with degenerative arthritis secondary to old septic arthritis underwent surgery. Case 2 as a child had bilateral septic hips. At the age of 44 years she underwent an arthrodesis of the right hip, after which she had a progressive loss of motion with increasing pain at the left hip. Following the cup arthroplasty she had almost complete pain relief and about a 60% gain in hip motion. Case 7, at age 30, had a tuberculous infection of the left hip incidental to which she lost most of her femoral head. Four years later she had an extra-articular arthrodesis performed, resulting in a pseudoarthrodesis. As noted, the patient had marked limitation of motion with severe pain in the hip. In this individual a trochanteric cup arthroplasty was performed. After one year the patient had only minimal hip pain and significant gain in motion. Both of these patients indicate the possibility of doing a cup arthroplasty for a symptomatic fibrous ankylosis.

Case 12 had a septic hip at the age of 16 after which she developed degenerative arthritis of the hip with pain and limited motion. A cup arthroplasty was performed, and after 10 months this patient experienced the anticipated pain relief. Her restoration of motion was less than expected, but she failed to carry out a satisfactory postoperative hip-care program. When on such a program she did well. This case indicates the importance of proper follow-up care with a careful exercise program and frequent rest periods.

Cases 3 and 5 are examples of idiopathic degenerative joint disease in the older group which we have already discussed. In the writers' opinion, people in the elderly group do not do as well with the cup arthroplasty. In the younger patient with degenerative arthritis, who is capable of a careful hip exercise program, we would anticipate good results.

Summary. Fourteen cases have been presented in which cup arthroplasty was performed. This is an early study but the authors' results indicate this is a procedure of promise for a variety of hip conditions in the young and middle-aged groups.

217 Wisconsin Avenue.

ACKNOWLEDGMENT: Case 2 was referred to us by Dr. Walter P. Blount. Throughout this entire study we have had great encouragement from Doctor Blount, which we appreciate. Case 3 is a patient of Dr. Bruce J. Brewer. Doctor Brewer has kindly allowed us to use this case in our series.

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ALPHA OMEGA ALPHA annual convocation will be held Friday, March 5, at 4 p.m. in Room 227, SMI Building, University of Wisconsin Medical Center, Madison. Dr. Victor McKusick, professor of medicine at Johns Hopkins University will deliver an address entitled, "Genetic Abnormalities in a Closed Society—A Study of the Amish." In the evening there will be initiation and a banquet at the Madison Club.

Acinic Cell Carcinoma of the Parotid Gland

By DALE E. VAN WORMER, M.D., Madison, Wisconsin

■ IN 1954 GODWIN et al[1] described the clinicopathologic features of 27 cases of acinic cell carcinoma of the parotid gland. Since then, two large series have been reported by Beahrs et al[2] and Grage et al.[3] Scattered case reports have also appeared.[4-13] The following case is being reported because it presents two unusual aspects of such tumors, namely lymph node metastasis and an unusual lymphoid stroma in the tumor. In addition to these points, it also affords a long-term follow-up of radiation therapy and reemphasizes the indolent nature of the malignancy of this type of tumor.

Case Report. A 20-year-old white female nursing student entered the hospital in May 1950 for the elective removal of a small mass anterior to her right ear. It had first been noted 1½ years previously and had continued to grow slowly. Although she noted an occasional sharp pain in the tumor area, there had been no facial weakness or change in salivation.

Physical examination revealed an obese woman with a mass 1.5 cm in diameter in the area of the parotid gland. It was tender on deep palpation and slightly movable. The preoperative diagnosis was mixed tumor. At the time of excision, the mass was described as well circumscribed and deep within the gland.

The patient had an uneventful postoperative course. However, she returned to the hospital in August 1951 because of a recurrent mass at the surgical site. She had first noted the small mass one year postoperatively. It gradually had increased in size and was associated with a dull, vague pain.

On physical examination the mass was described as 1.5 x 2.0 cm and as being fixed to the tissues beneath the previous incision. There was no facial weakness. Ten months later the tumor had returned in the site of excision and was again excised. Radiation therapy was started in June 1952 and discontinued in August. A total of 4,000 roentgens was given during 16 treatments. This was given with a 250-kilovolt machine using a single 6x6-cm port at a distance of 50 cm. The patient was asymptomatic until the spring of 1963 when she noticed a small nodule beneath the right mandible. It gradually enlarged but was painless. A well healed depression was present inferior and anterior to the right ear. A 2–3 cm nodule was palpable in the healed incision; and a 1.5-cm, moderately tender, smooth, movable nodule was palpable at the inferior border of the middle one-third of the mandible. There were no generalized symptoms or signs of weight loss. A frozen section was performed on the submandibular lymph node with a diagnosis of acinic cell carcinoma. A modified radical neck dissection was performed.

Pathologic Findings. The initial tumor measured 1.3 cm across and was moderately firm, well defined, and lobulated. The first recurrence was a 1.0x1.5–cm, nodular, brown mass. The second recurrence was a firm, hemorrhagic mass, 3.0 cm in diameter. Its cut surface was mottled with dense, firm, gray areas separating soft hemorrhagic tissue. The last specimen consisted of several lymph nodes and fibromuscular tissue (modified radical neck dissection). The largest node was 2.0 cm in diameter and was grossly replaced by gray, firm tumor. Two smaller nodes, each approximately 0.5 cm in diameter, also contained tumor on gross inspection.

The initial specimen was diagnosed on microscopic examination as a mucoepider-

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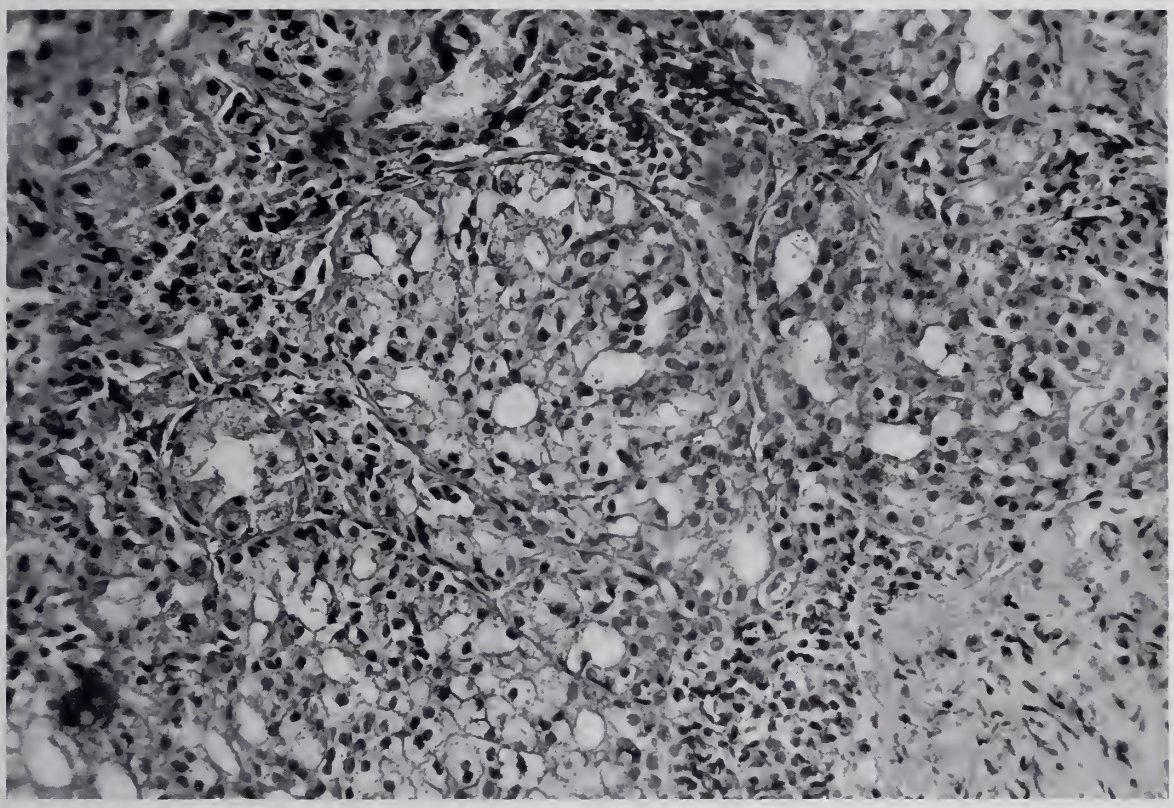

Fig. 1—High-power view demonstrating finely granular tumor cells with small, darkly staining nuclei (H&E X300).

moid tumor. As seen in Figure 1, it consisted of rounded or polygonal cells with small, dark eccentric nuclei and a finely granular, pale-staining, basophilic cytoplasm (H&E). Other cells had a water-clear cytoplasm and small cyst-like areas could be found. They did not stain positively with the PAS stain. One area of the tumor was predominantly glandular in appearance with some papillary formations. The recurrent tumors continued to have a lymphoid stroma which was fairly dense in some areas (Fig 2).

The microscopic diagnosis of the initial recurrence was adenoma of the parotid, the second recurrence was considered to represent an adenocarcinoma of the parotid gland with acinic formation. Except for the lymphoid stroma, the microscopic pattern seen in these specimens corresponds to the classic picture of closely packed cells supported by a small amount of vascular stroma. The cells, some of which have a finely granular basophilic cytoplasm, may be arranged in a pattern resembling acini. Other cells may have a large amount of clear cytoplasm and are the basis of the term hypernephroid adenoma which has been used in describing this tumor. Some cells may contain larger granules which are similar to the zymogenic granules seen in the acinic cells of the normal parotid gland. Ducts are not seen and although rather large vacuolated spaces are sometimes found, histochemical studies have shown no mucus. The acinic cell origin of this tumor has not as yet been definitely proven, but the histologic similarities and histochemical studies strongly support such a concept.

Discussion. Since the careful analysis of the clinical and pathologic aspects of 27 cases of acinic cell carcinoma by Godwin et al,[1] little has been added to our knowledge of their characteristics. The lesion closely simulates a mixed tumor clinically and occurs more than twice as frequently in females. The age range at the onset of symptoms is 16 to 85 years; however, they occur

most frequently in the fourth and fifth decades. The tumors have a long course with frequent recurrences, but lymph node metastases are unusual. The recurrence rate reported by Beahrs et al[2] was 55.5 per cent less than five years after the operation. They reported no regional lymph node metastases. Grage et al[3] reported a recurrence rate of 84 per cent in 7 patients treated by simple excision. In 2 of 11 cases there were regional node metastases. In the cases described by Godwin[1] there were 16 recurrences, or an incidence of about 60 per cent. Only one of the 27 cases in that series had regional node metastases. In none of the other 23 cases reviewed are lymph node metastases described. Thus, of a total of 85 cases, regional lymph node metastases were described in only 3. Widespread metastases have been recorded in 6 cases. The metastatic sites have been lung, bone, and vertebral column.

Although the five-year survival rate in a large series was recorded as 83.3 per cent,[14] this probably only reflects the indolent nature of this tumor. In the 11 cases reported by Grage et al,[3] 8 of the patients had been followed for more than five years, and of these, 3 had died from extensive local recurrence. The average time from onset of symptoms to death was 13 years. In a case reported by Rawson et al,[10] the tumor was first noted at the age of 4 years; and following multiple local recurrences, the patient died 30 years later of local and metastatic tumor.

Treatment has primarily been surgical dissection. Thirteen of the 85 cases reviewed had received radiation therapy. All of these had also had surgical excision, and the amount of radiation was not well documented in any of the reports. Of these cases, 3 had widespread metastases following radiation therapy, 7 had local recurrence, and no information is given in the other 3. Grage et al[3] noted that in the 4 cases treated with radiation in their group of 11, it was impossible to control the recurrent local disease. They felt this was predictable because of the high degree of differentiation of this tumor.

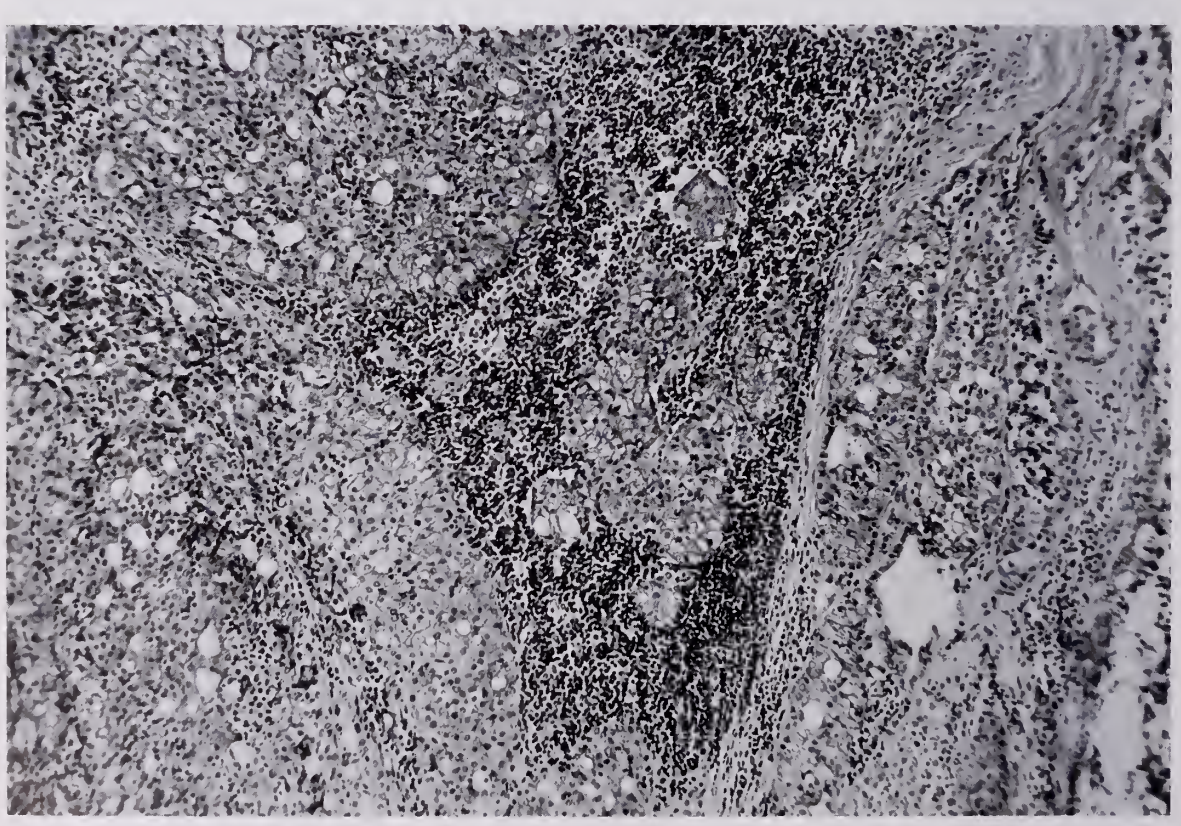

Fig. 2—Low-power view of tumor demonstroting the lymphoid stromo (H&E X150).

Summary. A case of acinic cell carcinoma with a 13-year history of four recurrences is reported. At the time of the last dissection, there was no local recurrence, but regional lymph node metastases were present, an unusual event in this tumor type. During an 11-year period after local excision and radiation therapy of 4000^{r}, no tumor was noted. The four tumors removed from this patient were histologically identical and demonstrated an unusual lymphoid stroma. Whether the presence of lymphocytes in the stroma of the tumor caused a more favorable response to radiation therapy is speculative.

A brief review of 85 reported cases is included and the indolent malignancy of this lesion is emphasized. None of the cases reviewed contained a description of a lymphoid stroma in the tumor. Although this patient's tumor metastasized to lymph nodes, radical neck dissection in all cases is probably not warranted. Frozen section studies of upper cervical lymph nodes at the time of the initial surgery might disclose an otherwise hidden metastasis. The probability of such a metastasis is unlikely, however, as the incidence of such an occurrence in the 85 cases reviewed was only 3.5 per cent. The initial surgical procedure should be one of radical local excision.

ACKNOWLEDGMENT: I should like to thank Dr. Kenneth Lemmer for permission to report this case.

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DR. ROBERT O. BECKER, SYRACUSE, N.Y., RECEIVES MIDDLETON AWARD FOR RESEARCH

The Dr. William S. Middleton Award, the Veterans Administration's highest honor for medical research, was presented early in December to Dr. Robert O. Becker, Syracuse, N.Y., for his work on the identification of electrical control systems in living organisms including man.

The presentation was made at the annual VA national research conference in Cincinnati, Ohio.

A certificate accompanying the award states, "As clinicians, we turn to research for the advancement of our practice." Doctor Becker's name has been added to a plaque which is being displayed during 1965 at the Syracuse VA Hospital, where he has been chief of the Orthopedic Section since 1956. The award was established in 1960 by colleagues of Doctor Middleton, who has since retired as chief medical director of the VA's Department of Medicine and Surgery.

General thesis of Doctor Becker's research work is that many biological activities, including growth and repair of injured parts, biological cycles and sleep, and the general level of nervous system activity, are controlled by previously unrecognized electronic control systems whose basic elements are various types of semiconducting properties within the different tissues of the body. These are believed similar to those of radio transistors and require only minute quantities of electrical current to make them work.

Doctor Becker, at the 1960 VA Research Conference, described the semiconduction system in the nerve fibers that controls the phenomenon of the regeneration of lost limbs in salamanders. Subsequent work has indicated that similar regeneration may control wound healing in all animals and humans.

There is some evidence that abnormal growths, such as cancer, may be related to the loss of this electronic control system.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: D. B. CLAUDON, M.D.
Milwaukee, Wisconsin

Case Presentation.* The patient, a 51-year-old white woman, was admitted to the hospital in January 1961 with complaints of nausea and vomiting of two weeks duration. She stated that she had been able to continue in her employment as a bank clerk until a few days before entering the hospital, but had had to eat every two hours and had been forced to subsist principally on a liquid diet. During a two month period her weight had fallen from 156 to 140 lb.

On admission laboratory determinations showed fasting blood glucose 81 mg per 100 ml, serum sodium 147 mEq per liter, serum potassium 2.8 mEq per liter, and serum chloride 108 mEq per liter, and carbon-dioxide combining capacity 27 mEq per liter. Serum calcium was 12.8 mg per 100 ml and serum phosphorus 1.9 mg per 100 ml. Blood urea nitrogen was 21 mg per 100 ml.

Her past medical history revealed that menarche had appeared at 13 years of age with normal menstruation for two years, followed by permanent amenorrhea. Appendectomy was performed when she was 26 years old for acute appendicitis. It was noted at this time that a male type escutcheon was present as well as prominent hirsutism of the thorax and lower extremities. The next year transient episodes of diplopia and numbness and a sense of "heaviness" in the lower extremities occurred, but the patient attributed these symptoms to nervous strain related to caring for her mother. Attacks of right renal colic occurred at age 33 years and 35 years respectively; in each instance calcium oxalate calculi were removed from the kidney at operation. In the interval between these procedures, complaints of indigestion and epigastric pain relieved by eating led to studies which confirmed the diagnosis of duodenal ulcer. Healing with disappearance of the ulcer followed one month of medical therapy.

Complaints of gradually increasing weakness of the lower extremities and diminution in control of bladder and anal sphincters over a three-week period occasioned another hospital admission in July 1947, six months after the second nephrolithotomy. Following extensive diagnostic studies the patient was discharged by the neurological consultants with a diagnosis of multiple sclerosis.

Subtotal gastric resection with gastrojejunostomy and bilateral vagotomy was performed in February 1950 when the patient was 40 years of age following two months of attacks of nausea, vomiting, and tarry stools. The pathology report was "benign duodenal ulcer." Symptomatic relief followed the operation until 1952 when a blood glucose determination of 54 mg per 100 ml was obtained while the patient was complaining of faintness and vertigo. Thereafter, whenever these symptoms appeared, she would drink sweetened orange juice for relief.

Routine x-ray examination of her chest in 1953 disclosed a "coin" lesion of the right middle pulmonary lobe. Resection of the nodule led to a pathologic diagnosis of "metastatic adenocarcinoma." In September 1953 exploratory laparotomy was performed in search for an islet cell tumor of the pancreas. The surgeon found the head of the pancreas "indurated" but failed to obtain a biopsy. He reported that the internal genitalia were atrophic and that the liver and retroperitoneal lymph nodes were normal.

A family history revealed that the patient's father had died at 49 years of age of hemorrhage from "ulcers of the stomach" and her mother at 46 years of age of gastric cancer. A sister died at 49 years of age of severe gastric bleeding. One surviving sister was in apparent good health.

Clinical Discussion. *Dr. M. Kellogg Mookerjee:* This case is presented in a somewhat different format than usual, since the diag-

* From Columbia Hospital.

nosis, in retrospect, from the data given in the protocol, is relatively easy. My objective is to illustrate the difficulties which were encountered during the lengthy course of the patient's illness and to describe the use of a therapeutic agent which was quite new at the time.

I will start by saying that although I was her personal physician from the date of the appendicitis attack onward, and had her confidence over the years, she was a most difficult and strong-willed woman. On numerous occasions she resisted or deferred diagnostic or therapeutic recommendations until forced to accept them by the severity of her symptoms. Until the terminal phase of her illness, the diagnostic and surgical procedures were performed in several hospitals by a variety of consultants, most of whom are now retired, or dead, and hence not available to discuss their part in her care.

This dispersion of her records made it difficult for any one of us to acquire the overall view which is now evident from the protocol; for purposes of brevity, many of the hospital admissions (total of 17) are not given. We suspected that she had hyperparathyroidism at the time of the second kidney operation in January 1947, but she would not permit us to confirm this by appropriate laboratory studies as a preliminary to surgical exploration of her neck.

The transient nature of her hypoglycemic attacks, initially, probably accounts for the delay in their recognition until one occurred in 1952 during an office visit. They possibly began as early as 1943. It is interesting that the two neurological consultants who studied her in July 1947 and arrived at a diagnosis of multiple sclerosis, did not consider this possibility—no blood glucose determinations were requested. Others have made the same mistake: Breidahl et al,[1] in a study of 91 cases of hyperinsulinism found that an incorrect initial diagnosis was made in 46; on long-range observation, the correct diagnosis was established on all patients. This is what happened in our case.

Another important diagnosis might have been established in September 1953 if the surgeon who performed the exploratory laparotomy had taken a biopsy of the pancreas. I do not know why he chose not to. It was not until May 1959 when the patient's symptoms had become very harassing that she consented to another abdominal exploratory

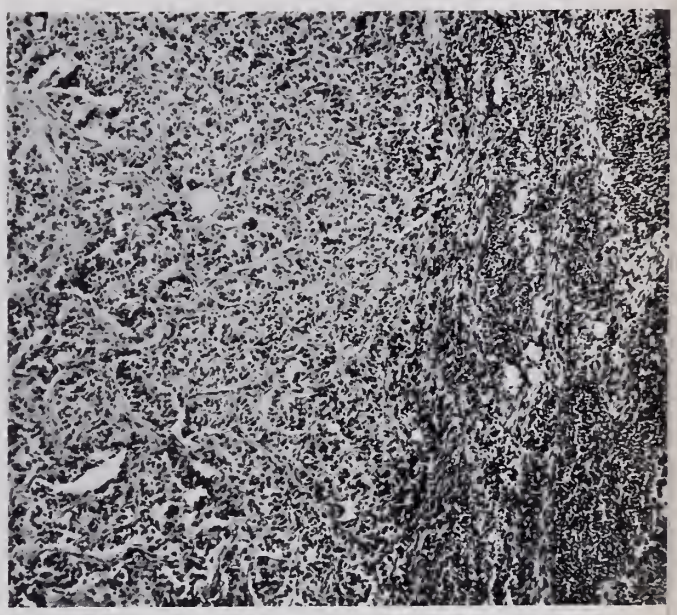

Fig. 1—Metastatic islet-cell carcinoma invading retroperitoneal lymph node (X90).

operation by another surgeon. This time biopsy of a hard mass in the head of the pancreas revealed what we rather expected—islet cell carcinoma. The tumor had metastasized to a peripancreatic lymph node but not to the liver. The pulmonary tumor sections were then re-examined and the tumor was considered to be the same.

During this admission we obtained laboratory data which confirmed the presence of hypercalcemia, hypokalemia, and hypoglycemia. Starting from a fasting value of 76 mg per 100 ml, an intravenous glucose tolerance test gave values of 145 mg at one-half hour, 88 mg at one hour, 79 mg at one and one-half hours, 76 mg at two hours, and 52 mg at three hours. Repeated determinations of serum calcium and phosphorus gave mean values of 12.4 and 2.2 mg per 100 ml, respectively. Tubular reabsorption of phosphate was 67% (normal 88–95%). Although calcium oxalate crystals were found in each of five morning urine specimens, intravenous pyelography demonstrated normal function and no renal calculi.

Daily oral administration of 75 mg of cortisone acetate (Cortisyl) was begun in May 1959 in hope that its diabetogenic action might favorably affect the persistent hypoglycemia. This did not happen, even with increased doses, and in October 1959

weekly supplementation with injections of 80 units of Acthar jel was begun.

In June 1959, glucagon hydrochloride (Glucagon)* was prescribed at a dose of 2 mg daily on the basis of the favorable report of its use by Landau, Levine and Hertz[2] in a patient with persistent hypoglycemia from a functioning islet-cell carcinoma. Hypoglycemic reactions were controlled by this agent for a short period, but with gradual onset of relapse the dose had to be increased to a maximum of 1.5 mg every 6 hours to secure a beneficial effect. Although the patient was able to resume her normal activities, blood glucose determinations consistently remained in the hypoglycemic range. On one occasion when the patient voluntarily stopped self-administration of glucagon hydrochloride, she went into hypoglycemic coma, but responded to intravenous infusion of glucose and resumption of the injections of glucagon hydrochloride.

In January 1961 the gastroenterostomy became obstructed, necessitating jejuno-jejunostomy. At this time the liver was studded with metastases. She had severe hypotensive episodes postoperatively, and died.

Our diagnosis was multiple adenomatosis of endocrine glands with islet-cell carcinomatosis.

I would like to add that whereas earlier[3] reports of cases of malignant islet-cell tumors of the pancreas indicated that they usually had a fulminating course and short survival time, Kernen et al[4] recently documented three cases living 9 years, 10½ years, and 13 years, respectively. Thirteen other cases, the longest survivor alive at 15 years, were gathered from the literature. My patient lived 24 years from onset of symptoms of hypoglycemia and received glucagon hydrochloride for a period of 20 months—the longest interval of continuous use of this agent of which I am aware.

Pathologic Discussion. *Dr. D. B. Claudon:* Pertinent autopsy observations concerned the endocrine glands and the abdominal viscera. A mass measuring 4.5 x 5 x 7 cm of greyish-pink, firm, homogeneous tissue with ill-defined borders replaced normal structures in the head and middle third of the body of the pancreas; remaining pancreatic tissue was normal. Many of the retroperitoneal and peripancreatic lymph nodes were replaced by tumor. Innumerable spheroidal nodules of tumor were distributed throughout the liver. No other metastases were found in the abdomen, nor were there any in the thoracic organs or the brain.

Microscopic examination confirmed origin of the neoplasm from islet cells. Review of the surgical specimens of 1953, 1959, and 1961 confirmed that they were of the same neoplasm.

Histochemical studies on sections from a block selected from the junction of the neoplasm and normal pancreatic tissue permitted comparison of appropriate selective stains on normal islet cells and tumor cells. The results were similar to those reported by Bloodworth and Elliott[5]: a few alpha- and beta-type cells were scattered through the neoplasm, but most of the cells were nonspecific in their reaction.

The pituitary gland measured 1.0 x 1.5 x 2.5 cm and lay within an enlarged sella. The anterior lobe was almost replaced by an encapsulated, soft, dull reddish-grey mass which microscopically consisted entirely of chromophobe cells.

Fig. 2—Adenama of pituitary gland.

* Made available by Dr. A. S. Ridolfo of the Lilly Laboratory for Clinical Research.

Fig. 3—Adenamas af parathyroid glands.

The thyroid gland was normal. Four enlarged parathyroid glands, the largest measuring 2 cm in maximum dimension, the smallest 1.5 cm, were found. On section, each had a smooth, bulging, glistening, tan-brown surface and a thin capsule. Histologically they were chief cell adenomas with an admixture of oxyphil cells.

Both adrenal glands were enlarged. The right gland measured 3.0 x 6.5 x 8.5 cm, the left one 2.5 x 5.5 x 9.0 cm. Each gland had numerous spheroidal cortical nodules of yellow-tan tissue from 0.5 to 1.5 cm in diameter, plus a brownish-black nodule measuring 1.0 x 1.5 x 2.0 cm in the medulla. Microscopically, the former were adenomas and the latter areas of hyperplastic, pleomorphic medullary cells. A small myelolipoma was also found in the medulla of the left gland.

Both ovaries were small and completely sclerotic. Seven shallow ulcers, the largest 2.5 cm, were distributed along the greater curvature of the gastric pouch. Microscopically they were benign. Gastric glands beyond the ulcers were unremarkable. The

Fig. 4—Adenamas of left adrenal gland.

gastroenterostomy stoma was stenosed by fibrous tissue; there was no evidence of tumor. The duodenal mucosa was intact.

The kidneys were normal in weight. Microscopically each had a mild degree of diffuse interstitial fibrosis and extensive deposits of calcium granules in cells of the distal convoluted tubules as well as in the scarred areas of cortex and medulla. Proximal convoluted tubules were vacuolated.

Final postmortem diagnoses were: (1) islet-cell carcinoma of pancreas with retroperitoneal lymph node and hepatic metastases, (2) adenomas of pituitary, parathyroid, and adrenal glands, (3) nephrocalcinosis and vacuolar nephropathy, (4) fibrous stenosis of gastroenterostomy stoma, and (5) bronchopneumonia.

In biochemical studies the bioassay was obtained through the cooperation of Drs. Donald B. Martin, Albert E. Renold and Jurgen Steinke of the Baker Clinic Research Laboratory, New England Deaconess Hospital, Boston, Mass. Arrangements were made in June 1959 for assays in Doctor Steinke's laboratory of the insulin-like activity (ILA) of samples of serum and insulin content of tissue specimens from the patient.

Serum ILA was determined by the oxidation of glucose 1–C^{14} to $C^{14}O_2$ by rat adipose tissue in vitro.[6] Results obtained on samples of serum secured three, five and eight months after beginning treatment with steroids and glucagon hydrochloride are given in Table 1. Analyses of tissue samples are recorded in Table 2.

Table 1 demonstrates that the insulin-like activity of the patient's serum was moderately elevated on different dates and had the usual inverse relationship to the concentration of glucose. However, the levels did not approach the maximum values (3,400 units per ml) found by Steinke et al[7] among a group of 16 cases of islet-cell adenoma of the pancreas. The lower value, that of the third specimen, was obtained 10 days before death when Doctor Mookerjee's patient was acutely ill from intestinal obstruction.

The normal, or slightly elevated, insulin concentrations recorded in Table 2 for the two postmortem tissue samples from the pancreas possibly reflect the decrease in mass of neoplastic cells as a result of necrosis and fibrosis. Support for this view comes from the almost hundred-fold increase above normal in insulin level[8] in the peripancreatic

TABLE 1—*Glucose and Insulin-like Activity in Serum of Fasting Patient*

Date of Specimen	Glucose (mg/100 ml)	ILA* (u units/ml)
August 19, 1959	20	766
October 10, 1959	14	830
January 26, 1961	32	440

*Normal value 250 u units/ml.

TABLE 2—*Insulin Levels in Tissue Samples from Patient*

Specimen	Weight (Gm)	Insulin* (units/Gm)
Surgical biopsy—May 14, 1959		
a. Peripancreatic lymph node	2.0	1.28
Postmortem—Feb. 5, 1961		
a. Tumor, head of pancreas	3.0	3.71
b. Tumor, body of pancreas	4.1	2.45
c. Peripancreatic lymph node	3.1	2.17
d. Liver, metastasis	17.1	less than 0.002
e. Adrenal	12.1	less than 0.001
*Normals: Pancreas		1 to 3
Adrenal, liver, lymph node		less than 0.03

lymph node metastasis where these changes had not occurred. The very low concentration of insulin in the hepatic metastasis, which was of comparable cellularity to the node lesion, may reflect insulinase activity of liver cells unavoidably included during preparation of the specimen for extraction and assay. The 70% greater value for insulin in the postmortem lymph node over that of the May 1959 node biopsy specimen (before glucagon hydrochloride therapy) may reflect retention of insulin within tumor cells as a result of the action of this agent.

Although Polacek and Ellison have reported[9] no evidence of any gastric secretion for as long as 5 hours after insulin-induced hypoglycemia of below 50 mg per 100 ml in dogs with Heidenhain (denervated) gastric pouches, the repeated demonstration of blood glucose levels below 50 mg per 100 ml in this patient, who had bilateral vagotomy in 1950 and multiple gastric ulcers at postmortem examination in 1961, suggests that other mechanisms of stimulating gastric acid secretion exist.

Albright and Kerr,[10] Black,[11] and Frame and Haubrich[12] have reported cases of hyperparathyroidism with coincident peptic ulceration. Although it remains unclear whether this is pure coincidence or a

casual relationship, one may note that this patient had two attacks of duodenal ulceration, the first responding to medical treatment, the second requiring operation, at a time when the clinical features were primarily those of hyperparathyroidism.

A strong family history of peptic ulceration and gastric carcinoma was recorded in the protocol. Doctor Mookerjee tells me that unfortunately the patient on several occasions refused gastric intubation, so we have no knowledge of her gastric function before or after subtotal gastrectomy. However, morphological examination of the gastrectomy specimen and the gastric remnant at autopsy did not reveal any of the changes characteristically seen in specimens from patients with the Zollinger-Ellison syndrome. While Summerskill et al[13] have recently pointed out that a striking similarity exists between patients with the Zollinger-Ellison syndrome and those with hereditary multiple endocrine adenomatosis, the evidence in this case does not clearly support such a relationship.

3321 N. Maryland Avenue.

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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Treatment of Cardiac Arrhythmias

By BERT K. B. LUM, M.D., Ph.D.
Milwaukee, Wisconsin

■ IN THE PAST, quinidine has been the principal agent used to abolish or suppress cardiac arrhythmias. However, successful therapy with quinidine frequently involves the use of large doses with the attendant high incidence of toxic reactions. Hypersensitivity reactions are not rare and in large doses, the drug may produce a symptom complex known as "cinchonism." The latter includes gastrointestinal upset, visual disturbances, tinnitus, headache, and a variety of other central nervous system disturbances. More seriously, toxic doses of quinidine may produce myocardial depression, cardiac standstill, and ventricular arrhythmias including fibrillation.

In the treatment of atrial fibrillation or atrial flutter, use of quinidine may result in the appearance of a dangerous "paradoxical tachycardia." The latter results from a slowing of the atrial rate by quinidine, thus allowing more impulses to pass through the A-V node to the ventricles. Prior digitalization to depress A-V nodal conduction may prevent the appearance of "paradoxical tachycardia."

The use of quinidine in the conversion of cardiac arrhythmias therefore requires careful attention to symptoms of toxicity and frequent monitoring of the electrocardiogram. Quinidine thus is far from ideal as an antiarrhythmic agent. Procainamide, an agent with therapeutic actions similar to quinidine has been purported to be safer and more effective; however, such claims have not been clearly established.

In recent years, the application of a brief direct current electric shock across the intact chest has been found to be a safe and effective means for terminating cardiac arrhythmias.[1] The brief electric shock causes depolarization of the entire myocardium, thus producing a momentary abolition of all pacemaker activity including that of ectopic origin. With repolarization, the sino-atrial node resumes as the dominant pacemaker because of its high inherent rhythmicity.

One potential danger is the deliverance of the electric shock during the "vulnerable" period of the cardiac cycle which can result in ventricular fibrillation. This occurs if the shock is given during the initial portion of the T wave of the electrocardiogram. This danger is obviated by the use of a "Cardioverter" with a synchronizer which permits deliverance of the electric impulse only during a "safe period" of the cardiac cycle.

Using the "Cardioverter," Lown and his associates[2] effected a 93% overall reversion rate to sinus rhythm in a series of 305 episodes of diverse arrhythmias in 240 patients. The method is simple, produces a prompt response, and is more effective than drug therapy. Serious complications in Lown's series were limited to three episodes of transient ventricular tachycardia. It thus appears that electric reversion will largely supplant the use of antiarrhythmic drugs. However, cardioversion does not obviate the use of antiarrhythmic drugs. The latter are needed as maintenance therapy in cases of frequent recurrence of the arrhythmias following electric reversion.

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W. P. CURRAN, M.D.
Antigo, Wisconsin

SMS Realty Corporation

■ IN 1951 THE State Medical Society became concerned with the problem of inadequate space in the quarters that it then owned on Gorham Street in Madison. By 1952 that building, a converted residence, housed 51 employees and the reasonable capacity was not over 35. The Society was then in process of installing IBM equipment and the management of the Society was confronted also with the fact that the staff was growing steadily.

In a meeting of the Council in October 1952, the whole problem was reviewed with a determination to purchase property on Lake Monona and to organize a realty corporation to handle a new building program.

The Society in that year became the owner of the parcel of land on which its present building and west wing addition now stand. The frontage on Lake Monona is 366 feet which was purchased for $18,991.74, or a cost of approximately $50 per front foot. It is interesting to note that in an independent appraisal by a Madison realtor in July 1961, he stated the "opinion" that the then fair market value of the bare land of this property was $65,000. This is about $177 per front foot of lakeshore.

The Council had a planning committee consisting of Doctors H. Kent Tenney and Nels A. Hill, both of Madison, and E. M. Dessloch of Prairie du Chien, and it reported to the Council in March 1953 its recommendation that:

> "The property and building, to be effectively managed, to assure proper financing, and for other reasons should be held by a Realty Corporation under the control and direction of the State Medical Society through its councilors and officers."

This was approved by the Council, and articles of incorporation were recorded in June 1953. In August of that year the Council was individually polled on the long-range planning which was by then completed, and in a roll call vote unanimously approved the report of the committee and staff.

Plans for the new building were completed early in 1954 with low bids totaling $355,925, with some special equipment totaling $5,967.60, for a total of $361,892.60.

Every member of the Council and officers was then polled and it was determined to go ahead with construction with the temporary elimination of air conditioning. In July 1955 the building was ready for occupancy and was formally dedicated in October of that year. Final construction cost of the building including architect fees was $370,535.54.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

For the Future

■ WITH GOOD CAUSE for pride, medical scientists can review the accomplishments of 1964—as well as the several years preceding it—as being among the most significant in the history of mankind. New techniques, new insights, new discoveries have preserved life, reduced its hazards, and extended its duration. Beginning with new ways to lower the rate of infant mortality, medical science has whittled away at mortality in surgical procedures, controlled certain types of life-ending cancers, and generally enabled people to look forward to a much longer life expectancy.

As a result of the spectacular advance of medical science in the past decade, we can expect more people to live and more people to live longer. But what of the people whose lives are saved and lengthened? Are they being preserved to eke out a miserable existence in conditions of overcrowding, economic uncertainty, and in spiritual and intellectual darkness?

Some of the social problems we face are derived from the fact that we are still working under a system that was developed when the limit of our material resources was beyond the limit of our imagination. Many of our laws are reflexes of a time when a man forty-five years of age was a senior citizen, and society's right of control was reinforced and extended by the natural operation of the conditions of life. Now, however, with the conditions of life changed by the advance of science, should there not be another look at the role of our laws affecting the behavior of a population that has changed, if for no other reason than by its sheer numbers?

The tendency to turn back to the "good old days" is always with us. There is a substantial number of citizens in the United States who think that to set the clock back by fifty years would contribute some kind of a solution to a problem they refuse to define. They fail to face the fact that as medical science has changed, so has the reality of daily existence, and that new solutions must be found for problems that have arisen from the progress that has been made under the successful solutions that were found fifty years ago. If nothing else, the spectacular advance of medical science in the past decade forces us to face to the future and honestly confront the consequences of our progress.

What, then, can doctors do about the consequence of our own success? Shall we call a halt to medical progress on the premise that we are interfering with a balance of nature? Shall we return to the theory that he who survives is mysteriously "fit" to survive? Most medical scientists would reject such ideas without discussion, for the rationale of science is progressive, outwardly developing. Science can't be made to regress.

But scientists can take a greater interest in the social affairs of their communities, and it is in the possibility of the scientist becoming socially involved that the salvation of our modern society lies. The logic of scientific method need not be confined to the laboratory, nor is the human condition such that it can't be studied to find a workable truth on which to predicate a satisfactory control.

If the result of medical progress isn't to be poured down a cesspool of social and economic calamity, scientists must look beyond their immediate fields of operation and consider the entire environment that they are creating. As they have a stake in the future, they have a responsibility to speak for a total vision of the good life—not one freed from physical ills but beset with moral and social rot.

Plato wrote that the ideal republic of virtue depended on philosophers becoming kings and kings philosophers. Today more than ever our social salvation depends on scientists becoming statesmen, and statesmen—or politicians, if you like—becoming scientific. —D.N.G.

Equity Needed

IF ANYONE HAD any doubt that more money ought to be spent to encourage qualified young people in the pursuit of careers in the medical sciences, recent figures compiled by the Association of American Medical Colleges ought to clinch the argument.

According to the report only 17% of the medical students enrolled during 1962–1963 received non-refundable aid (such as fellowships, scholarships, research, teaching assistantships, and the like). Such grants averaged $585. By comparison, 68% of all arts and science students enrolled in the same period received non-refundable grants, and their grants averaged $2,450.

The Association observes that ". . . financing a higher education obviously poses a greater problem for the average medical student than for the average graduate student." With one-fourth as many grants available and each grant worth about one-fourth as much, it is small wonder that talented students of limited financial means might be forced to forego a medical career in favor of a profession in which they stood a chance of stronger financial support.

President Johnson's national health program holds out the promise of federal aid to attract capable people for the health professions and to keep them in school once they have started. The direction was indicated by the Health Professions Educational Assistance Act of 1963, which still remains to be fully utilized. As they are proposed the elements of the health care program that look toward increasing the supply of medical scientists should be supported. —D.N.G.

Lesson from Industry

C. WESLEY MEYTROTT, vice-president of Consolidated Edison Company of New York, made an interesting suggestion for lowering the costs of hospital care. Writing in *Trustee* the Journal for hospital governing boards, Mr. Meytrott advised hospital managements to look around to see what private industry had done about rising costs in the face of increasing utilization.

Drawing from his own experience in the electric utility field, he recalled that early electric power systems planned power generating stations for every square mile. As electricity came into greater use, and as competing systems developed, powerhouses proliferated, and each powerhouse, he said, operated as though it were the only powerhouse in the world. The cost of electricity skyrocketed.

The break came, according to Meytrott, with the development of high-voltage transmission lines, thus eliminating the need for the neighborhood powerhouse. They made possible the construction of large, efficient

powerhouses serving many communities. They also made possible cooperation between companies, allowing them to share facilities and thereby holding down the cost of power.

Hospitals, says Meytrott, could do the same. By pooling services, community planning, and institutional coordination, hospitals could assure more complete utilization of existing facilities, operational economies, and a broader spectrum of high quality care. By undertaking such common industrial practices as central computer or data processing service, central laundry service, group purchasing, coordinated specialty laboratory services and centralized emergency ambulance facilities, the hospitals could reduce the cost of their own operation and pass the savings on to the patient.

It takes a special creative imagination and a capacity for incisive evaluation to run a complicated business efficiently and economically. That such talents have not abounded in the field of hospital management is in part demonstrated by the fantastic increase in the cost of hospital care in the last twenty years. Certainly Meytrott's ideas for cost-cutting present a challenge that ought to be explored. While some of them may not be practical in detail, at least the principle he suggests offers an alternative to the simple-minded solution of constantly sticking the patient with higher prices. —D.N.G.

PRESIDENT'S PAGE *continued from page 117*

Subsequently the air conditioning installation was completed.

Total direct use was 25.68% by the association activities of the Society and 74.32% by the prepaid plans. General use areas such as the library, interview room, Council room, and other areas were allocated on a square foot basis in proportion to the direct use. The advice of independent realtors has been used from time to time to determine that the square foot rental was within the market range of Madison office properties.

It should be noted that a parking lot surfaced to accommodate 90 cars is available, and in subsequent years the Dane County Medical Society principally financed the construction of the Stovall Memorial Wall at Lakeside Street, and other individuals and county societies have contributed to the physical beauty of the location.

In an appraisal earlier referred to it was reported that replacement costs in 1961 were higher than those of original construction. The building has operated continuously since the original construction under the Realty Corporation. Rents have been adjusted from time to time, and the west wing was completed in November 1962.

At this point we should summarize the arrangements for retiring the indebtedness. WPS, as a division of the State Medical Society, holds two mortgages, the first in the principal amount of $270,000 at an interest rate of 4%. It is dated Sept. 10, 1955, and is due in 40 years. The second is in the amount of $375,000 at the rate of 5.5%. It is dated Dec. 31, 1962, and is due Dec. 31, 1982. To summarize:

On the 1955 mortgage of $270,000, $20,000 of principal has been retired leaving a balance due of $250,000 at 4%. On the 1962 mortgage for $375,000, only $348,500 was actually borrowed, at interest of 5.5%, and $7,108 of principal has been retired, leaving a balance of $341,392. Therefore, total indebtedness of the Realty Corporation at Jan. 31, 1965, is $591,392.

Beginning Jan. 1, 1964, scheduled payments were planned, first to retire the higher interest mortgage, and secondly that bearing the lower interest.

The physicians in Wisconsin can feel proud of the building location and of the wisdom of those who saw its development as far back as the early 1950s. Delegations from the medical societies in Iowa and Indiana among others have visited the building to use its experience in the construction and operation of their own. With the present structure, meetings may be brought to the home of medicine; and the building, all in all, is serving an admirable purpose and is efficiently operated.

Our congratulations to the physicians of Wisconsin, the staff of our State Society, and all who had a part in the planning and foresight which led to the completion of our medical society home in Madison.

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ANNUAL MEETING PROGRAM

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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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DEAR DOCTOR:

The Commission on Scientific Medicine is pleased to direct your attention to the Preliminary Program of the 1965 Annual Meeting, as completed by February 1.

The latter part of March you will receive a special folder, outlining the various noon scientific luncheons. **As attendance is limited, we suggest you make reservations for these as soon as possible after the folder has reached your desk.**

We are particularly happy to announce a special feature of the meeting, on Thursday, May 6. This will be a series of papers by Residents, as noted in the program, and the two best presentations will be given a cash award of $100, with one winning lecture associated with the name of William S. Middleton, M.D., and the second associated with the name of Harry Beckman, M.D.

Attention is also directed to the new character of the Annual Dinner. While not a direct responsibility of the Commission on Scientific Medicine, we are pleased to note that President Curran has designated this as "an evening of fun and fellowship." We feel sure many physicians and their wives will be pleased with the social atmosphere of the Annual Dinner this year.

We urge you to set aside the dates of May 4, 5, and 6 so you can attend at least a portion of the Annual Meeting program. By working closely with the specialty societies and the Wisconsin Academy of General Practice, we have developed a program of quality and diversity. **You can help it succeed by your attendance!**

Sincerely,

P. T. BLAND, M.D.
Chairman, Commission
on Scientific Medicine

GEORGE COLLENTINE, M.D.
Program Chairman

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

P. T. BLAND, M.D. ____ Westby
Chairman

G. E. COLLENTINE, JR., M.D. ____ Milwaukee
General Program Chairman

JOHN K. CURTIS, M.D. ____ Madison
Luncheons

THOMAS V. GEPPERT, M.D. ____ Madison
Scientific Exhibits

EDGAR S. GORDON, M.D. ____ Madison
Special Assignments

JAMES WEYGANDT, M.D. ____ Sheboygan Falls

WARREN SIMMONS, M.D. ____ Rhinelander

W. T. RUSSELL, M.D. ____ Sun Prairie

OVID MEYER, M.D. ____ Madison

ALBERT MARTIN, M.D. ____ Milwaukee

Ex officio:

GERALD A. KERRIGAN, M.D. ____ Milwaukee
Acting Dean, Marquette University School of Medicine

V. S. FALK, JR., M.D. ____ Edgerton
Medical Editor, The Wisconsin Medical Journal

1965 Annual Meeting Timetable

SUNDAY, MAY 2

12:00 M: Council Luncheon: Hotel Schroeder

p.m.
2:00 Council Meeting: Hotel Schroeder
5:30 Council Dinner: Hotel Schroeder

MONDAY, MAY 3

p.m.
6:00 Buffet supper for Delegates and Officers: Hotel Schroeder
7:00 First Session of House of Delegates: Hotel Schroeder

TUESDAY, MAY 4

a.m.
8:30 Registration and Opening of Exhibits: Milwaukee Auditorium
9:00 Reference Committees of the House of Delegates: Hotel Schroeder
10:00 Scientific Meetings: Internal Medicine and Radiology: Milwaukee Auditorium
10:30 Council Meeting: Hotel Schroeder

p.m.
12:30 Luncheon of Marquette Medical School Alumni Assn.: Milwaukee Auditorium
12:30 Clinic Managers Luncheon: Coach House Motel
12:30 Scientific Luncheons: Hotel Schroeder
2:00 Scientific Meetings: Internal Medicine, Obstetrics and Gynecology, Pathology, and Radiology: Milwaukee Auditorium
4:00 Board of Directors, Wisconsin Society of Pathologists: Hotel Schroeder
5:30 Auxiliary Board Meeting (followed by dinner): Hotel Pfister
7:30 Second Session of House of Delegates: Hotel Schroeder
8:00 "Fireside Conferences" of Wisconsin Chapter, American College of Chest Physicians: Hotel Schroeder
(Dinners of Wisconsin Radiological Society and University of Wisconsin Alumni Assn.)

WEDNESDAY, MAY 5

a.m.
8:30 Registration: Milwaukee Auditorium
9:00 Opening of Exhibits: Milwaukee Auditorium
9:00 Third Session of House of Delegates: Hotel Schroeder
10:00 Scientific Programs: General Practice and Dermatology-Pediatric "Wet Clinic": Milwaukee Auditorium
10:00 Auxiliary Business Meeting: Hotel Pfister

p.m.
12:30 Scientific Luncheons: Hotel Schroeder
1:00 Auxiliary Luncheon: Milwaukee Athletic Club
2:00 Scientific Meetings: Dermatology, Orthopedic and Plastic Surgery, and Pediatrics: Milwaukee Auditorium
6:30 President's Reception: Milwaukee Auditorium
7:15 Annual Dinner: Milwaukee Auditorium
(Dinner of Wisconsin Society of Orthopedic Surgery)

(continued next column)

TIMETABLE continued

THURSDAY, MAY 6

a.m.
8:30 Registration: Milwaukee Auditorium
9:00 Opening of Exhibits: Milwaukee Auditorium
10:00 Scientific Program: Resident Competitive Papers: Milwaukee Auditorium
(Wisconsin Surgical Society meets at Milwaukee County Hospital for morning scientific program, members only)
10:00 Otology: Milwaukee Auditorium
10:00 Auxiliary Business Meeting: Hotel Pfister

p.m.
12:30 Scientific Luncheons: Hotel Schroeder
12:30 Past President's Luncheon: Hotel Schroeder
1:00 Auxiliary Luncheon: Hilton Inn
2:00 Scientific Programs: Anesthesiology, Ophthalmology, and Surgery: Milwaukee Auditorium
3:45 Close of Exhibits: Milwaukee Auditorium
5:00 Otology: Hilton Inn
(Dinners: Wisconsin Society of Anesthesiologists, Wisconsin Surgical Society, and Milwaukee Oto-Ophthalmic Society)

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time Tuesday, 8:30 a.m.–4:30 p.m.; Wednesday 8:30 a.m.–4:00 p.m.; and Thursday, 8:30 a.m.–3.30 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Senior and junior medical students will be admitted on Wednesday and Thursday, May 5–6. Medical assistants and hospital personnel will be admitted on Thursday, May 6 *only, after 11:00 a.m.* Interns and residents will be admitted without registration fee, any time during meeting, *if certified by hospital.* Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies will be admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING

Give Your Secretary This Information

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—271–9609. For Milwaukee MDs, *Direct call through 273–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—271–7250. Tell your secretary the room number of the luncheon, so we can locate you!

PRESS and STAFF ROOM
Room 509
HOTEL SCHROEDER

TUESDAY, MAY 4

SPECIAL PROGRAMS ARRANGED IN COOPERATION WITH:

Wisconsin Society of Internal Medicine
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Pathologists
Wisconsin Radiological Society

8:30—REGISTRATION AND TIME TO VIEW EXHIBITS

INTERNAL MEDICINE

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Special Program on "Coronary Angiography"

Moderator: GEORGE E. GUTMANN, M.D., Janesville, President, Wisconsin Society of Internal Medicine

10:00—CORONARY ANGIOGRAPHY AND EXERCISE TOLERANCE

Albert A. Kattus, Jr., M.D., Los Angeles

Professor of Medicine, (Cardiology), Chief of the Division of Cardiology, School of Medicine, University of California at Los Angeles

(Lecture sponsored by the Wisconsin Heart Association)

10:45—HEMADYNAMIC EFFECTS OF CARDIOVERSION

Robert Corliss, M.D., Madison

Instructor in Medicine, University of Wisconsin Medical School

11:00—RECESS TO VIEW EXHIBITS

11:30—DISCUSSION AND QUESTIONS

Moderator: ROBERT CORLISS, M.D., Madison

Richard Wasserburger, M.D., Madison
Dean Emanuel, M.D., Marshfield
Albert A. Kattus, Jr., M.D., Los Angeles

NOTE: Special luncheon with Doctor Kattus as speaker. See page 15 for details.

(Afternoon Session)

2:00—Seminar on "Diagnosis and Therapy of Pulmonary Embolism, Value of Pulmonary Arteriography, Pulmonary Scans, and the Place for Surgery"

Moderator: DEAN EMANUEL, M.D., Marshfield

2:00—MEDICAL DIAGNOSTIC ASPECTS

Dean Emanuel, M.D., Marshfield

2:15—PULMONARY SCANS

Robert C. Meade, M.D., Wood

Veterans Administration Medical Center

2:30—RADIOLOGIC ASPECTS

Thomas Olsen, M.D., Marshfield

2:45—SURGICAL ASPECTS

Richard Sautter, M.D., Marshfield

3:00—RECESS TO VIEW EXHIBITS

3:45—QUESTIONS AND ANSWERS

Doctors Emanuel, Meade, Olsen, and Sautter

OBSTETRICS AND GYNECOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: LEO GRINNEY, M.D., Racine
President, Wisconsin Society of Obstetrics and Gynecology

2:00—PREMATURE RUPTURE OF THE FETAL MEMBRANES

Keith P. Russell, M.D., Los Angeles

Clinical Professor of Obstetrics and Gynecology, University of Southern California School of Medicine

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—DYNAMICS OF IRON METABOLISM IN PREGNANT WOMEN

Roy Holly, M.D., Philadelphia

Professor and Chairman of the Department of Obstetrics and Gynecology, Jefferson Medical College, Pa.

NOTE: Noon luncheons will be arranged with both Doctors Russell and Holly as speakers. See p. 15 for details.

PATHOLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: EDWIN L. BEMIS, M.D., Milwaukee
Program Chairman, Wisconsin Society of Pathologists

Albert A. Kattus, Jr., M.D.

Keith P. Russell, M.D.

TUESDAY *continued*

John B. Henry, M.D.

Kurt Amplatz, M.D.

2:00—PERSPECTIVES IN CLINICAL ENZYMOLOGY

Conrad A. Elvehjem Memorial Lecture

John B. Henry, M.D., Syracuse

Professor of Pathology and Director of Clinical Pathology, State University of New York, Upstate Medical Center

2:30—SERUM ENZYME ALTERATIONS IN MYOCARDIAL INFARCTION

David J. LaFond, M.D., Milwaukee

2:50—SERUM ENZYME ALTERATIONS IN HEPATOBILIARY DISEASE

Raymond Voet, M.D., Milwaukee

3:10—RECESS TO VIEW EXHIBITS

3:45—PANEL DISCUSSION AND QUESTIONS

Doctors Henry, La Fond, and Voet

NOTE: A noon luncheon will be arranged with Doctor Henry as speaker. See p. 15 for details.

RADIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: THEODORE J. PFEFFER, M.D., Milwaukee
President, Wisconsin Radiological Society

10:00—INFUSION PYELOGRAPHY

June Unger, M.D., Wood

Veterans Administration Medical Center

10:15—VENOUS PHASE—CEREBRAL ANGIOGRAPHY

James Nellen, M.D., Milwaukee

10:35—PEDIATRIC RADIOLOGICAL TECHNIQUE

Donald Babbitt, M.D., Milwaukee

10:55—SAME DAY RE-ENFORCEMENT CHOLECYSTOGRAPHY

Andrew B. Crummy, M.D., Madison

11:10—RECESS TO VIEW EXHIBITS

12:15—RADIOLOGY LUNCHEONS *(See p. 16 for details)*

(Afternoon Session)

Moderator: JOSEPH WEPFER, M.D., Milwaukee

2:00—RADIOLOGICAL TREATMENT OF DEGENERATIVE JOINT DISEASE

Gordon D. Vi Gario, M.D., and Halvor Vermund, M.D., Madison

Department of Radiology, University of Wisconsin Medical School

2:15—GENERAL RADIOLOGY AND THE SPECIAL PROCEDURES

Kurt Amplatz, M.D., Minneapolis

Associate Professor of Radiology, University of Minnesota School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:45—LOWER ESOPHAGEAL RING

Richard Schatzki, M.D., Boston

Associate Clinical Professor of Radiology, Harvard Medical School, Cambridge, Mass.; and Chief, Department of Radiology, Mount Auburn Hospital, Cambridge

4:15—SEPTIC PULMONARY EMBOLI

F. Frank Zboralske, M.D., West Allis

4:35—BUSINESS MEETING OF SECTION ON RADIOLOGY

NOTE: During noon hour, both Doctors Amplatz and Schatzki will conduct luncheon discussions. See p. 16 for details

In the evening the Wisconsin Radiological Society will have a dinner (members only) with Doctor Schatzki as speaker. Reservations for this will be made with the Secretary of the Radiological Society after notice on the dinner is sent all members.

U. of W. MEDICAL SCHOOL ALUMNI ASSOCIATION

DINNER MEETING—TUESDAY, MAY 4. Coach House Motor Inn—Milwaukee. Speakers: JAMES W. NELLEN, M.D., Green Bay, and a member of the PACKERS Football Team Staff. Reservations to: Ralph Hawley, 418 N. Randall Ave., Madison, Wis. 53706

Richard Schatzki, M.D.

Carl M. Pearson, M.D.

HOUSE OF DELEGATES

BALLROOM, HOTEL SCHROEDER

(Evening Session)

7:00—The Second Session of the House of Delegates will be held at the Hotel Schroeder on Tuesday evening.

FIRESIDE CONFERENCES

FIFTH FLOOR, HOTEL SCHROEDER

(Evening Session)

8:00—The Wisconsin Chapter of the American College of Chest Physicians will present a series of informal "Fireside Conferences" on a variety of subjects, in the East Room and Pere Marquette Room of the Hotel Schroeder. Program arranged by SYDNEY T. GETTELMAN, M.D., West Allis. Free beer for all those in attendance!

1. CHRONIC AND DEGENERATIVE LUNG DISEASE
   - (a) EMPHYSEMA
   - (b) CHRONIC BRONCHITIS
   - (c) PULMONARY FIBROSIS
   - (d) BRONCHIECTASIS
   - ETC.
2. MANAGEMENT OF CARDIOPULMONARY EMERGENCIES
   - (a) CARDIAC RESUSCITATION
   - (b) DRUG AND INHALATION THERAPY—RECENT ADVANCES
3. INFECTIOUS DISEASES OF LUNG—VIRAL, BACTERIAL, FUNGAL, AND TUBERCULOUS

   PROBLEMS RELATING TO MANAGEMENT
4. ALLERGIC PULMONARY DISEASE AND ASTHMA

   INCLUDING VASCULITIS AND CONNECTIVE TISSUE DISORDERS
5. CHEST X-RAY READING
6. PROBLEMS OF ELECTROCARDIOGRAPHIC INTERPRETATION
7. VALUE OF PHYSICAL EXAMINATION OF THE HEART
8. INFLAMMATORY DISEASES OF THE HEART
   - (a) RHEUMATIC DISEASE
   - (b) PERICARDITIS
   - (c) MYOCARDITIS
   - ETC.
9. MANAGEMENT OF HYPERTENSIVE DISEASE; CORONARY DISEASE AND CARDIAC DECOMPENSATION; EMPHASIS ON ADVANCES IN DRUG THERAPY
10. DIAGNOSIS AND MANAGEMENT OF VALVULAR AND CONGENITAL HEART DISEASES—MEDICAL AND SURGICAL ADVANCES
11. MALIGNANT AND BENIGN NEOPLASTIC DISEASES OF THE CHEST—DIAGNOSTIC TECHNIQUES AND MANAGEMENT

WEDNESDAY, MAY 5

Two general programs have been developed for the morning period, 10 a.m. to 12 noon, and special programs on the subjects of Dermatology, Pediatrics, and Orthopedic and Plastic Surgery have been arranged for the afternoon.

PROGRAMS PREPARED IN COOPERATION WITH:

Wisconsin Academy of General Practice
Wisconsin Dermatological Society
Wisconsin Society of Orthopedic Surgery
Wisconsin Chapter, American Academy of Pediatrics

GENERAL PRACTICE

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: W. D. HAMLIN, M.D., Mineral Point
President, Wisconsin Academy of General Practice

10:00—AUTOIMMUNE DISEASE

Carl M. Pearson, M.D., Los Angeles

Associate Professor of Medicine, University of California School of Medicine at Los Angeles

10:45—RECESS TO VIEW EXHIBITS

11:15—PANEL ON "ASTHMA"

Moderator: HOWARD J. LEE, M.D., Milwaukee

David M. Glassner, M.D., Milwaukee
Milton M. Mosko, M.D., Chicago
Charles E. Reed, M.D., Madison

NOTE: A noon luncheon will be conducted by Doctor Pearson. *See p. 16 for details.*

A SPECIAL ANNUAL MEETING FEATURE

MEDICAL ART SALON

Milwaukee Auditorium, May 3–6

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin

(See the February issue of WMJ for details)

DERMATOLOGY-PEDIATRICS

Wet Clinic on "Adolescence"

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: ROBERT B. PITTELKOW, M.D., Milwaukee

10:00—CASE REVIEWS AND DISCUSSIONS

Actual cases will be provided by Milwaukee dermatologists, and special discussants will be:

Carl W. Laymon, M.D., Minneapolis

Clinical Professor of Dermatology, University of Minnesota School of Medicine, and

Arthur Roth, M.D., Oakland, Calif.

Pediatrician in Private Practice

10:45—RECESS TO VIEW EXHIBITS

11:15—CONTINUATION OF CASES AND DISCUSSION

NOTE: Both Doctors Laymon and Roth will conduct noon luncheon discussions. See p. 16 for details.

DERMATOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: RICHARD ROWE, M.D., Marshfield
President, Wisconsin Dermatological Society

2:00—CUTANEOUS MANIFESTATIONS OF SOME INTERNAL DISEASES

Carl W. Laymon, M.D., Minneapolis

Clinical Professor of Dermatology, University of Minnesota School of Medicine

2:45—RECESS TO VIEW EXHIBITS

3:15—CLINICAL ASPECTS OF DERMAL SCLEROSIS

Sture A. M. Johnson, M.D., Madison

Professor of Dermatology, University of Wisconsin Medical School

Carl W. Laymon, M.D.

Arthur Roth, M.D.

Leonard Marmor, M.D.

Carroll B. Larson, M.D.

3:35—THE RADIOLOGIST LOOKS AT DERMAL SCLEROSIS

F. Frank Zboralske, M.D., West Allis

Assistant Professor of Radiology, Marquette University School of Medicine

ORTHOPEDIC SURGERY AND PLASTIC SURGERY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: HERMAN W. WIRKA, M.D., Madison
President, Wisconsin Society of Orthopedic Surgery

2:00—SURGERY OF RHEUMATOID ARTHRITIS

Leonard Marmor, M.D., Los Angeles

Associate Professor of Orthopedic Surgery, University of California School of Medicine, Los Angeles

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—DEGENERATIVE HIP DISEASE

Carroll B. Larson, M.D., Iowa City

Professor and Chairman of the Department of Orthopedic Surgery, State University of Iowa College of Medicine

4:30—DISCUSSION

NOTE: Doctor Marmor will conduct a noon luncheon program. See p. 16 for details.

The Wisconsin Society of Orthopedic Surgery will have a dinner (members only), with Doctor Larson as speaker. Members will receive a notice on this from the Secretary of the Wisconsin Orthopedic Society.

Be sure to visit the

PHYSICIANS' PHOTOGRAPHY EXHIBIT

An outstanding collection!

PEDIATRICS

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: STEWART GRIGGS, M.D., Green Bay
President, Wisconsin Chapter of the American Academy of Pediatrics

2:00—ADOLESCENTS AND THEIR PROBLEMS: Physical and Mental

Arthur Roth, M.D., Oakland, Calif.

Pediatrician in Private Practice

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:45—INFORMING AND TEACHING PARENTS OF DISTURBED CHILDREN

Thomas Linton, Ph.D., Milwaukee

Director, Emotionally Disturbed Children Program, University of Wisconsin—Milwaukee

NOTE: Doctor Roth will conduct one of the noon luncheon conferences. *See p. 16 for details.*

PRESIDENT'S RECEPTION AND ANNUAL DINNER

BALLROOM, HOTEL SCHROEDER—7:15 p.m.

President Curran has decreed that the Annual Dinner will be strictly social and will follow the theme of "an evening of Fun and Fellowship." The Marquette Medical School Glee Club will sing during the Dinner. Dancing, during dinner and following a floor show, will be provided by Grant Krueger and His Orchestra "The Executives." Following brief talks by the President and the President-Elect, and granting of special citations, the remainder of the evening will be a floor show and dancing! PLAN TO ATTEND AND HAVE FUN WITH YOUR WIFE AND OTHER COUPLES WHO WILL BE IN ATTENDANCE.

THURSDAY, MAY 6

Special Program Presented by Residents of Wisconsin Hospitals

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

This is a special feature which we hope will be attended by many members of the State Medical Society. The six contestants will present papers and a panel of three judges will select the two best, each to receive a cash award:

$100—The William S. Middleton Lecture

$100—The Harry Beckman Lecture

Winning lectures will be published in the Wisconsin Medical Journal

Judges are: OVID O. MEYER, M.D., Madison, Member of Commission on Scientific Medicine; VICTOR S. FALK, M.D., Edgerton, Medical Editor of the Wisconsin Medical Journal; and NORBERT BAUCH, M.D., Milwaukee, representing the Wisconsin Academy of General Practice

(Morning Session)

Moderator: P. T. BLAND, M.D., Westby
Chairman, Commission on Scientific Medicine

10:00—THE USE OF PERITONEAL LAVAGE IN THE TREATMENT OF ACUTE PANCREATITIS IN DOGS

Larry C. Carey, M.D., Milwaukee

Resident in Surgery, Milwaukee County Hospital

10:15—Discussant: E. H. ELLISON, M.D., Milwaukee

10:20—MERCURY INTOXICATION SIMULATING INTRA-ABDOMINAL SURGICAL CONDITIONS

Walter Schwindt, M.D., Madison

Resident in General Surgery, University Hospitals

10:35—Discussant: ROBERT C. HICKEY, M.D., Madison

10:40—THE ANATOMICAL ISOLATION OF THE DOG BRAIN FOR USE AS A RESEARCH TOOL

Morris B. Glover, M.D., Madison

Resident in Neurosurgery, University Hospitals

10:55—Discussant: M. J. JAVID, M.D., Madison

11:00—PARTIAL GASTRECTOMY FOR PEPTIC ULCER DISEASE

John E. Clemons, M.D., La Crosse

Resident in General Surgery, Lutheran Hospital

11:15—Discussant: ADOLF L. GUNDERSEN, M.D., La Crosse

11:20—SIX MONTHS' EXPERIENCE WITH CARDIO-RESPIRATORY RESUSCITATION

Philip J. Taugher, M.D., Marshfield

Resident in Medicine, St. Joseph Hospital

11:35—Discussant: DEAN EMANUEL, M.D., Marshfield

11:40—THE NATURAL HISTORY OF METAPHYSEAL DYSOSTOSIS

Arlan L. Rosenbloom, M.D., Madison

Resident in Pediatrics, University Hospitals

11:55—Discussant: HENRY OKAGAKI, M.D., Madison

12:00—DECISION OF JUDGES ON WINNING PAPERS

OTOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Morning Session)

Moderator: LEE EBY, M.D., Milwaukee

10:00—SIGNIFICANCE AND EVALUATION OF NECK SWELLING

Francis L. Lederer, M.D., Chicago

Professor and Head of the Department of Otolaryngology, University of Illinois College of Medicine

10:45—RECESS TO VIEW EXHIBITS

11:00—PANEL ON "CARCINOMA OF THE LARYNX"

Moderator: FRANCIS L. LEDERER, M.D., Chicago

James H. Brandenburg, M.D., Madison
Anthony Grueninger, M.D., Milwaukee
Rollo Lange, M.D., Madison
Patrick Noonan, M.D., Milwaukee

NOTE: At noon the otologists will join the ophthalmologists for lunch and a business meeting as the Section on EENT. Following lunch and the business meeting there will be a special program on ophthalmology, and all those interested are urged to attend.

At 5:00 p.m. Doctor Lederer will speak on "Influence of Environmental and Medical Progress on Otolaryngology" at joint meeting of Wis. Otolaryngology Society and Milwaukee Oto-Ophthalmic Society at Hilton Inn.

ANESTHESIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: SHERMAN C. MYERS, M.D., Milwaukee
President, Wisconsin Society of Anesthesiologists

2:00—THE SELECTION AND MANAGEMENT OF ANESTHESIA IN CARDIAC PATIENTS

E. M. Papper, M.D., New York City

Professor and Chairman, Department of Anesthesiology, College of Physicians & Surgeons, Columbia University; and Director, Anesthesiology Service, Presbyterian Hospital

2:30—RESPIRATORY PHYSIOLOGY OF THE NEWBORN

David Allan, M.D., Chicago

Director, Department of Anesthesiology, Children's Memorial Hospital, Illinois

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON "THE PLACE AND VALUE OF INHALATION THERAPY IN THE PRE- AND POSTOPERATIVE PERIOD

Moderator: JAMES BARBOUR, M.D., Madison

E. M. Papper, M.D., New York City
David Allan, M.D., Chicago
Karl Siebecker, M.D., Madison
J. J. Jacoby, M.D., Milwaukee

E. M. Popper, M.D.

Dovid Allon, M.D.

NOTE: Both Doctors Papper and Allan will conduct noon luncheon discussions. See p. 16 for details.

In the evening the Wisconsin Society of Anesthesiologists will hold a dinner (members and wives only) and social gathering. Members will receive a notice on this from the Secretary of the Wisconsin Society of Anesthesiologists.

OPHTHALMOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

All ophthalmologists and otolaryngologists will meet for lunch in Juneau Hall at 12:15 p.m., as the Section on EENT. Following the business meeting (around 1 p.m.), there will be a special program on ophthalmology.

Moderator: MATTHEW D. DAVIS, M.D., Madison

2:00—CHRONIC CONJUNCTIVITIS

Samuel J. Kimura, M.D., San Francisco

Professor of Ophthalmology, University of California School of Medicine, San Francisco Medical Center

2:45—DISCUSSION

3:00—EYE INFECTIONS IN CHILDREN

Richard O. Schultz, M.D., Milwaukee

3:45—DISCUSSION

NOTE: The Milwaukee Oto-Ophthalmic Society will host a dinner at Hilton Inn, Milwaukee, beginning at 6:30 (preprandial hour at 5:30). Doctor Kimura will speak at 8:30 on "Uveitis in Children." ADVANCE RESERVATIONS REQUIRED BY APRIL 20. Send check of $6.00 to Wm. Bennett, M.D., 524 Main St., Racine. ALL EENT PHYSICIANS INVITED TO ATTEND.

Samuel J. Kimura, M.D.

Alton Ochsner, M.D.

SURGERY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

(Afternoon Session)

Moderator: NORMAN BECKER, M.D., Fond du Lac
President, Wisconsin Surgical Society

2:00—POST-GASTRECTOMY STATUS—A STANDARD INDEX FOR EVALUATION

Adolf L. Gundersen, M.D., La Crosse

2:15—PANEL DISCUSSION: Surgical Management of Blunt Trauma to the Abdomen

Moderator: E. H. ELLISON, M.D., Milwaukee

Joseph Wepfer, M.D., Milwaukee
L. W. Worman, M.D., Milwaukee
R. G. Wochos, M.D., Green Bay

2:55—PRESIDENTIAL ADDRESS: Changing Truths

Irwin Schulz, M.D., Milwaukee

3:15— RECESS TO VIEW EXHIBITS

3:25—SURGERY FOR ACQUIRED VALVULAR HEART DISEASE USING THE HINGED LEAF VALVE

V. L. Gott, M.D., Madison

Assistant Professor of Surgery, University of Wisconsin Medical School

3:40—SURGICAL TREATMENT OF ULCERATIVE DISEASE OF THE STOMACH AND DUODENUM

(William Beaumont Memorial Lecture of the CES Foundation of the State Medical Society of Wisconsin)

Alton Ochsner, M.D., New Orleans

Emeritus Professor of Medicine, Tulane University School of Medicine

4:10—PANEL DISCUSSION: Surgical Management of Thromboembolic Disease

Moderator: ROBERT HICKEY, M.D., Madison

Donald Koepke, M.D., Madison
Dean Emanuel, M.D., Marshfield
Alton Ochsner, M.D., New Orleans

NOTE: The Wisconsin Surgical Society will conduct a dinner on Thursday evening. Notice will reach members of the Wisconsin Surgical Society through John Mendenhall, M.D., Madison, Secretary.

LUNCHEONS

ALL 3 DAYS

TUESDAY, MAY 4

12:30—LUNCHEONS at Hotel Schroeder

All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested. See page 18.

INTERNAL MEDICINE

1. IATROGENIC HEART DISEASE AS I HAVE SEEN IT

Albert Kattus, Jr., M.D., Los Angeles

Chairman: George Gutmann, M.D., Janesville

EAST ROOM—5TH FLOOR

OBSTETRICS AND GYNECOLOGY

2. THYROID DISEASE IN PREGNANCY

Keith P. Russell, M.D., Los Angeles

Chairman: William Wendt, M.D., Milwaukee

PARLOR A—4TH FLOOR

3. ABNORMAL UTERINE BLEEDING

Roy Holly, M.D., Philadelphia

Chairman: Leo Grinney, M.D., Racine

ENGLISH ROOM—5TH FLOOR

PATHOLOGY

4. PERSPECTIVES IN CLINICAL ENZYMOLOGY

John B. Henry, M.D., Syracuse

Chairman: Robert Haukohl, M.D., Milwaukee

PERE MARQUETTE ROOM—5TH FLOOR

LUNCHEONS *continued*

PUBLIC HEALTH

5. **HEMORRHAGE IN RELATION TO MATERNAL DEATHS IN WISCONSIN**

C. Weir Horswill, M.D., Madison
(Chairman of Interviewers, Maternal Mortality Survey)
Parlor E—4TH FLOOR

RADIOLOGY

6. **SPECIAL PROCEDURES IN RADIOLOGY**

Kurt Amplatz, M.D., Minneapolis
Chairman: John Amberg, M.D., Milwaukee
PARLOR C—4TH FLOOR

7. **GLOBUS HYSTERICUS**

Richard Schatzki, M.D., Boston
Chairman: Abraham Melamed, M.D., Milwaukee
PARLOR D—4TH FLOOR

NON-SCIENTIFIC LUNCHEON

8. **MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION**

JUNEAU HALL, MILWAUKEE AUDITORIUM, 12:15 p.m. Make reservations to: David Hartnett, 1834 West Wisconsin Avenue, Milwaukee 53233. Cost: $2.50, including service. Make checks payable to Marquette University Alumni Association.

WEDNESDAY, MAY 5

12:30—**LUNCHEONS** at Hotel Schroeder

All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested. See page 18.

DERMATOLOGY

1. **TREATMENT OF VARIOUS FORMS OF ALOPECIA**

Carl Laymon, M.D., Minneapolis
Chairman: Richard Rowe, M.D., Marshfield
Room 508—5TH FLOOR

INTERNAL MEDICINE

2. **PERITONEAL DIALYSIS**

Robert Burns, M.D., Madison
ROOM 507—5TH FLOOR

3. **RECENT CLUES ABOUT THE ETIOLOGY OF RHEUMATOID ARTHRITIS**

Carl Pearson, M.D., Los Angeles
Chairman: Charles Reed, M.D., Madison
PERE MARQUETTE ROOM—5TH FLOOR

PEDIATRICS

4. **ADOLESCENTS "BUG" THE PEDIATRICIAN**

Arthur Roth, M.D., Oakland, Calif.
Chairman: Carl Beck, M.D., Wauwatosa
ENGLISH ROOM—5TH FLOOR

ORTHOPEDIC SURGERY

5. **REPAIR OF THE PERIPHERAL NERVE EFFECTS BY IRRADIATED HOMOGRAFT**

Leonard Marmor, M.D., Los Angeles
Chairman: Herman Wirka, M.D., Madison
EAST ROOM—5TH FLOOR

SURGERY

6. **WHAT'S NEW IN SURGERY**

Edwin H. Ellison, M.D., Milwaukee
PARLOR A—4TH FLOOR

7. **THYROID DISEASE**

Robert C. Hickey, M.D., Madison
PARLOR C—4TH FLOOR

THURSDAY, MAY 6

12:30—**LUNCHEONS** at Hotel Schroeder

All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested. See page 18.

ANESTHESIOLOGY

1. **INFANT RESUSCITATION IN THE DELIVERY ROOM**

David Allan, M.D., Chicago
Chairman: George Kreuter, M.D., Milwaukee
ENGLISH ROOM—5TH FLOOR

2. **INVESTIGATION OF RESPIRATORY DISEASES PRIOR TO ANESTHESIA**

E. M. Papper, M.D., New York City
Chairman: Ernest Henschel, M.D., Milwaukee
PERE MARQUETTE ROOM—5TH FLOOR

INTERNAL MEDICINE

3. **NEWER DRUGS AND THEIR USES**

Ovid O. Meyer, M.D., Madison
PARLOR C—4TH FLOOR

4. **DRUG REACTIONS**

William S. Middleton, M.D., Madison
PARLOR A—5TH FLOOR

LUNCHEONS *continued*

PEDIATRICS

5. **DIAGNOSIS OF CONGENITAL HEART DISEASE**

Thomas Meyer, M.D., Madison

ROOM 507—5TH FLOOR

NON-SCIENTIFIC LUNCHEON

6. **PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY**

PARLOR G—5TH FLOOR

All Past Presidents and the President-Elect of the State Medical Society are invited to attend this courtesy luncheon.

House of Delegates

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Reference committees will meet Tuesday morning, with reports to be made at the Tuesday night, or second, session. Other business, including election of officers and councilors, will be held Wednesday morning, at the final session.

Society members are urged to participate in the discussions on reports, resolutions and nominations before the committees Tuesday morning. Reference committees will close their sessions at noon in order to prepare reports for the evening session of the House of Delegates.

SCHEDULE

MONDAY, MAY 3

p.m.

6:00 BUFFET SUPPER for Delegates, Alternates and SMS Officers, Hotel Schroeder, East Room, 5th floor

6:30 REGISTRATION of the House of Delegates, Hotel Schroeder, 5th floor foyer

7:00 FIRST SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

TUESDAY, MAY 4

a.m.

9:00 REFERENCE COMMITTEE MEETINGS of the House of Delegates, Hotel Schroeder

COMMITTEE ON NOMINATIONS, Pine Room, 5th floor

COMMITTEE ON RESOLUTIONS and Amendments to the Constitution and Bylaws, Crystal Ballroom, 5th floor

COMMITTEE ON REPORTS OF OFFICERS, Room 507, 5th floor

COMMITTEE ON REPORTS OF STANDING COMMITTEES, Room 508, 5th floor

p.m.

7:30 SECOND SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

WEDNESDAY, MAY 5

a.m.

9:00 THIRD SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

Annual Dinner

WEDNESDAY EVENING
May 5

President Curran has decreed this to be an evening of

"Fun and Fellowship"

Strictly a social function!

President's Reception
6:30 P.M.

Annual Dinner
7:15 P.M.

Presentation of Fifty-Year Club Awards

Marquette Medical School Glee Club

Dancing to the Music of the Executives

Professional Floor Show!

JACK PYLE
Humorist, Magician, Master of Ceremonies

FARRELL SISTERS
Musical Duo

BENNY MEROFF & KATHLEEN
Comedy Act

THE IVY FIVE
Singing Act—A Favorite In Chicago!

MAIL YOUR ADVANCE REGISTRATION TODAY

See page 18

RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 2 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities and taxes.

TUESDAY, MAY 4 (See pages 15 and 16 for listing)

IMPORTANT: Those making reservations for the Marquette Luncheon and U. of W. Alumni Dinner please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. KATTUS: Iatrogenic Heart Disease
2. RUSSELL: Thyroid Disease in Pregnancy
3. HOLLY: Abnormal Uterine Bleeding
4. HENRY: Perspectives in Clinical Enzymology
5. HORSWILL: Hemorrhage in Relation to Maternal Deaths in Wisconsin
6. AMPLATZ: Special Procedures in Radiology
7. SCHATZKI: Globus Hystericus

Name of Leader

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 5 (See page 16 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. LAYMON: Treatment of Various Forms of Alopecia
2. BURNS: Peritoneal Dialysis
3. PEARSON: Recent Clues about the Etiology of Rheumatoid Arthritis
4. ROTH: Adolescents "Bug" the Pediatrician
5. MARMOR: Repair of Peripheral Nerve Effects of Irradiated Homograft
6. ELLISON: What's New in Surgery
7. HICKEY: Thyroid Disease

Name of Leader

First Choice: _____ Second Choice: _____

THURSDAY, MAY 6 (See pages 16 and 17 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. ALLAN: Infant Resuscitation in Delivery Room
2. PAPPER: Investigation of Respiratory Diseases Prior to Anesthesia
3. OVID MEYER: Newer Drugs and Their Uses
4. MIDDLETON: Drug Reactions
5. THOMAS MEYER: Diagnosis of Congenital Heart Disease

Name of Leader

First Choice: _____ Second Choice: _____

ANNUAL DINNER, Wed., May 5

DANCING—FLOOR SHOW
SHORT SPEECHES—COCKTAILS

$8.00 PER PERSON (Including Gratuities and Taxes)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $ _____

Number Annual Dinner Tickets ($8.00 each) . . _____ for $ _____ TOTAL $ _____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____

(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701

Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Monday, May 4	8:00 a.m.–5:00 p.m.
Tuesday, May 5	9:00 a.m.–5:00 p.m.
Wednesday, May 6	9:00 a.m.–3:45 p.m.

(Exhibits "break up" at 3:45 p.m. on Wednesday, May 6)

IN MAIN EXHIBIT HALL

S–2—ILEOSTOMY APPLIANCE CUSTOM-FITTED BY THE SURGEON

JOHN R. BENFIELD, MD, and GERALD C. GANT, MD, Department of Surgery, University of Wisconsin Medical School, Madison; and GEORGE W. BARNHART, Zoller Memorial Biological Plastic Research Laboratory, University of Chicago, Chicago, Ill.

The variability of ileostomy stomas may present challenging problems in management to the surgeon, patient, and appliance maker. Significant improvement can be obtained by using silicone rubber materials yielding exact imprints of the stoma and surrounding skin detail, resulting in the perfect fit required by some patients to prevent skin irritation and breakdown. These techniques can be applied by the surgeon shortly after operation in order to obtain a functional appliance as soon postoperatively as possible. Should modification of the face plate become necessary as the stoma matures and changes, it can easily be accomplished by the surgeon or his assistants in the office or outpatient clinic. Models and demonstration will be provided.

S–3–4—DIAGNOSIS AND TREATMENT OF PULMONARY THROMBO-EMBOLISM

RICHARD D. SAUTTER, MD, and DEAN A. EMANUEL, MD, Marshfield Clinic Foundation for Medical Research and Education, Marshfield

Exhibit will illustrate diagnosis and treatment of pulmonary embolism. Special emphasis will be placed on new techniques in pulmonary arteriography, peripheral cannulization for instituting cardiopulmonary bypass, simple and rapidly assembled apparatus for cardiopulmonary bypass, and methods for removal of the emboli. Angiograms and case histories selected from 30 cases of pulmonary emboli in our series will be shown emphasizing use of the above techniques. Indications for surgical or nonsurgical treatment will be presented.

S–5—PITUITARY ADRENAL AXIS IN HEALTH AND DISEASE

FRANCIS N. LOHRENZ, MD, Marshfield Clinic Foundation for Medical Research and Education, Marshfield

One section of the exhibit will outline in diagramatic form the pituitary adrenal axis with normal values of the hormones produced at appropriate levels. Another section will consist of four rotating panels demonstrating four patients: (1) patient with Cushing's syndrome before and after total adrenalectomy, (2) patient with ectopic ACTH-producing syndrome, (3) patient demonstrating acromegaly, and (4) patient demonstrating hypopituitarism. A third panel will list the primary symptoms and clinical findings which should suggest a systematic pituitary adrenal laboratory evaluation emphasizing the baseline studies which should be performed. This will be followed by the appropriate stimulation with ACTH and/or suppressive studies as indicated.

S–6—ABDOMINAL SURPRISES

THE BEAVER DAM MEDICAL FORUM, Beaver Dam

An exhibit of colored pictures of gross and microscopic anatomy of cases which were tentatively diagnosed as one thing, but proved to be of a very surprising nature when the abdominal cavity was opened, also some colored pictures of pathology as it appeared upon or in the patient. There will be a summary of the history and physical and laboratory findings which led to the tentative preoperative diagnosis. By lifting a flap the viewer will see the "surprise."

S–7—UNUSUAL MANIFESTATIONS OF RENAL NEOPLASMS

WM. G. RICHARDS, MD, THEODORE ROWAN, MD, and E. BRUCE WOHLWEND, MD, Clinical Pathology Laboratory, Beaver Dam

A number of cases of renal tumors which first presented with bizarre symptoms and/or signs will be exhibited. Emphasis on cytologic and enzymatic aids (urinary lactic dehydrogenase) in diagnosis will be stressed. Photographs of x-rays, color photographs of gross specimens, and photomicrographs will be used. Sample cases: (1) 45-year-old white male presenting with a swelling in right index finger. Eventual diagnosis: metastatic renal cell carcinoma. (2) 30-year-old white male, gym instructor presenting with bloody urine after a fall from a Trampoline. Eventual diagnosis: renal cell carcinoma. (3) 62-year-old white male with symptoms and x-ray signs suggestive of multiple myeloma. Urinary LDH—abnormally elevated, urine cytology, class V. Eventual diagnosis: renal cell carcinoma. (4) 58-year-old white male with suspected retroperitoneal sarcoma, pleural fluid, and pleural biopsy diagnosed as reticulum cell sarcoma. Final diagnosis: renal cell carcinoma.

S–8–9—IDENTIFICATION OF HEART SOUNDS "PHONO-CARDIOGRAPHY"

WISCONSIN HEART ASSOCIATION in cooperation with Marquette University and the University of Wisconsin medical school staffs

Self-testing unit on evaluation of abnormal heart sounds and murmurs as a diagnostic technique, with test booklets and explanation of each case presented. Sounds also available on an oscillos. ope. Physicians can test their ability to detect abnormalities.

S–10–11—PROLIFERATIVE DIABETIC RETINOPATHY

M. D. DAVIS, MD, R. L. ENGERMAN, PhD, and Y. L. MAGLI, BS, University of Wisconsin Medical School, Madison

The natural course of proliferative diabetic retinopathy will be illustrated with fundus diagrams and stereoscopic

fundus photographs. Proliferative retinopathy begins with the growth of new vessels along the inner surface of the retina. These cause vitreoretinal adhesions. Later, vitreous contraction pulls the new vessels forward into the vitreous cavity. Vitreous hemorrhage and retinal detachment often follow. Spontaneous "regression" of the retinopathy is not unconmon. The exhibit will consist chiefly of stereo fundus photographs contained in appropriate viewers.

S–12—APPENDICITIS IN PREGNANCY

FLORIDA DY, MD, and GEORGE S. WOODWARD, MD, Evangelical Deaconess Hospital, Milwaukee

This exhibit presents the spectacular alteration in the anatomic relationships, incidence, difficulties in diagnosis, and management of appendicitis in pregnancy. The modified technic for appendectomy during the third trimester advocated by some authors is described. Prophylactic appendectomy in all laparotomies in fertile women is recommended.

S–13—VAGINAL APPROACH TO GYNECOLOGIC SURGERY, A SPINAL ANESTHETIC TECHNIQUE

EDGAR HABECK, MD, and ROBERT A. SCHMIDT, MD, Evangelical Deaconess Hospital, Milwaukee

Exhibit consists of colored photographs, anatomical drawings, and descriptive material showing the advantages and technique of hypobaric Dibucaine spinal anesthesia. The exhibitors' results and experiences with this anesthetic agent over a period of years in gynecologic surgery by the vaginal route at the Evangelical Deaconess Hospital in Milwaukee is presented.

S–14—PREPERITONEAL HERNIA REPAIR

KENNETH A. SEIFERT, MD, (and THOMAS UITHOVEN, Medical Illustrator), Evangelical Deaconess Hospital, Milwaukee

Exhibit demonstrates the technique of preperitoneal hernia repair. This is accomplished by means of slides and illustrations. The repair of femoral, indirect, and direct groin hernias is illustrated. The advantages and disadvantages of this method are shown on lighted illustrations.

S–15—DIAGNOSIS OF STOMACH LESIONS WITH GASTRO CAMERA

JAMES RICHARD HOON, MD, The Sheboygan Clinic, Sheboygan

A series of transparent full color enlargements of gastro camera diagnostic photographs with explanatory text, including pictures of gastric carcinoma, ulcers, gastritis, and other findings, and photographic demonstration of operation of the gastro camera. Scope and practicality of use of gastro camera in private medical practice is demonstrated.

S–16—ROENTGEN SIGNS OF TUMORS OF CECUM

M. MOEL, MD, and L. K. MARK, MD, Mt. Sinai Hospital, Milwaukee

Exhibit will demonstrate the roentgenologic signs of tumors of the cecum and an attempt will be made to differentiate malignant from benign lesions. Examples of early and late changes of malignancy of the cecum as well as benign conditions will be shown.

S–17—LEUKOCYTIC CHROMOSOMAL ANALYSIS

JULIA A. BACKUS, MD, Resident Pathologist, Department of Pathology, St. Luke's Hospital, Milwaukee

Chromosomal analysis of leukocytes derived from peripheral blood is a useful technique in the investigation of congenital abnormalities and some neoplastic conditions. Commercially available kits have simplified the sample preparation technology. Microscopy and photography are facilitated by the Zeiss automatic photomicroscope. The technology will be outlined and demonstrated photographically. Representative chromosomal spreads and their corresponding karyotypes will be portrayed in studies of mongolism and acute lymphoblastic leukemia. Other established clinical applications of such studies will be elaborated.

S–18—ANGIOKERATOMA CORPORIS DIFFUSUM (FABRY'S DISEASE)

FRANK STILES, MD, and JOHN OPITZ, MD, The Monroe Clinic, Monroe, and University of Wisconsin Medical School, Madison

Purpose of this exhibit will be to familiarize the Wisconsin physician with angiokeratoma corporis diffusum. Clinical, diagnostic, biochemical, and genetic features will be described. The pedigree of a Wisconsin family which includes 22 cases will be shown. This disease is a sex-linked, hereditary disorder characterized by extremity pain, a typical rash, cardiovascular—renal lesions, and corneal dystrophy.

S–19—"BARN ITCH"—TRICHOPHYTON VERRUCOSUM INFECTION IN MAN

ROBERT R. BAUMANN, MD, The Monroe Clinic, Monroe, and Clinical Instructor in Dermatology, University of Wisconsin Medical School, Madison

Ringworm acquired from dairy cattle is an important health hazard to Wisconsin farm families. It will be the point of this exhibit to demonstrate in a succinct manner etiology, clinical picture, office diagnostic methods, and treatment of this entity. That "barn itch" is protean in its manifestations will be stressed (e.g. the pustular variety is frequently confused with staphylococcal pyoderma). Enlarged clinical photographs, in color, will be used extensively. This will be an original, "home-grown" effort, and not a professionally sponsored exhibit.

S–20—INFUSION PYELOGRAPHY

JUNE DeBOER UNGER, MD, Veterans Administration Hospital, Wood

Exhibit will consist of a brief description of technique of infusion pyelography, advantages, indications, and contraindications. Remainder of the exhibit will be devoted to demonstration of various pathologic renal conditions by radiographic visualization during infusion studies. Clinical correlation of findings and ease of procedure will be stressed. Included will be polycystic renal disease, avascular hypernephroma, visualization in the presence of elevated BUN levels (up to 135 mg per 100 ml at present), medullary sponge kidney, chronic pyelonephritis, and unilateral hypertensive renal disease.

S–20A—RADIOISOTOPE ORGAN SCANS

ROBERT C. MEADE, MD, and PHILIP RUETZ, MD, Veterans Administration Center, Wood

Exhibit will demonstrate radioisotope scanning of brain tumors, liver, kidney, spleen, lung, bone tumors, and the thyroid, with illustrative cases to demonstrate the clinical uses. Isotopes used and techniques involved will be illustrated. It is hoped that a scanner can be included in the exhibit so that the actual operation of the equipment can be visualized.

S–20B—LABORATORY TESTS FOR INFECTIOUS DISEASE

STATE LABORATORY OF HYGIENE, University of Wisconsin Medical School, Madison

Some programs of interest to physicians that are being expanded by the State Laboratory of Hygiene. Included will be: (1) Services for development and quality control of local laboratories; (2) Research activities in respiratory disease and encephalitis.

S–20C—WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

These valued MD assistants will be on hand to indicate how their association is of assistance to members, and in turn of assistance to employer physicians.

S–21–22—HIRSCHSPRUNG'S DISEASE IN THE NEWBORN

MARVIN GLICKLICH, MD, St. Joseph's Hospital, Milwaukee

Hirschsprung's disease in the newborn period may present varying clinical pictures which differ from that in the older child. Low intestinal obstruction, temporary obstruction, distention due to dilated colon, and perforation should lead us to suspect the diagnosis. Findings will vary depending upon the extent of involvement. Confirmation of the diagnosis requires rectal or colonic biopsy demonstrating aganglionosis. Colostomy, properly placed through normal colon, is the treatment of choice in the newborn period.

S–23—STEROID ANALYSIS BY GAS CHROMATOGRAPHY

J. MASSART, MD, J. BARETA, MD, C. H. ALTSHULER, MD, and RICHARD NENSEL, St. Joseph's Hospital, Milwaukee

Techniques suitable for the gas chromatographic analysis of 17-ketosteroids, estrogens, and progestins will be illustrated. This will include procedures for hydrolysis, extraction, cleanup, derivitization, and chromatography. The results of some of these analyses and their pertinence to clinical medicine will be described.

S–24—MEGALOBLASTIC ANEMIA OF PREGNANCY

HAROLD J. CONLON, MD, and DANIEL P. COLLINS, MD, West Allis Memorial Hospital, West Allis, and Marquette University School of Medicine, Department of Pathology, Milwaukee

On the back panel a commercial artist will portray a discussion of: What it is, the hazards presented to mother and infant, the incidence, symptoms, diagnosis, therapy, and prognosis of the disease entity. A programmed slide projector, projecting in a closed mirror—ground glass system, will be in the center with pictures of typical patients, peripheral smears, and bone marrow aspirate. The left panel will go into details of metabolic pathways and point out its relationship to pernicious anemia. The right panel will contain a discussion of the Formimino-L-Glutamic Acid Test (FIGLU Test) as the definitive diagnostic tool. In each corner will hang a three-dimensional model of the DNA molecule. Literature will be available.

S–25—HOMEMADE BOMBS

GEORGE FLYNN, MD., and FREDERICK BUNKFELDT, JR., MD, Columbia Hospital, Milwaukee

The majority of injuries to the hand, face, and abdomen from explosives occur in boys between the ages of 14 and 17. Models of some of the specific types of bombs and rockets made from materials about the home will be shown. Fourteen or more blast injuries will be described. Slides showing the initial injury, x-rays, and treatment will be shown. The message is to inform the adult when this group of students becomes interested in explosives, in order to prevent these unnecessary injuries.

S–26—TREATMENT OF THYROID CANCER

PHILIP H. SEEFELD, MD, and JOHN O. CHAMBERLAIN, MD, Columbia Hospital, Milwaukee

Exhibit will consist of special view-cases to display transparencies and text material. The subject will be the treatment of thyroid cancer by surgery and radioisotopes with illustrations of isotope scans, and clinical photographs of surgical specimens.

S–27–28—WISCONSIN SOCIETY OF PATHOLOGISTS and SECTION ON PATHOLOGY

Demonstrations of Gross Tissue Pathology

Careers in the Medical Laboratory

EXHIBITS ON STAGE

S–29—THE CASE FOR RESEARCH WITH ANIMALS

Wisconsin Society for Medical Research, Inc.

This colorful two-panel exhibit depicts, by means of photographs and message, the problems and solutions offered in connection with the use of animals in medical research. It represents an enlightened approach to the use of animals in a research program. Photographs depicting a modern animal research facility are included.

S–30—THE WATA'S "OPERATION KO–TB"

Wisconsin Anti-Tuberculosis Association, Milwaukee

The WATA's revolutionary TB casefinding program, "Operation KO-TB," is depicted in color and illustration. Lighted panels show administrations of the chest x-ray and tuberculin skin test that have been given free-of-charge to 150,000 state adults and children in two years. A revolving pictorial pylon explains how it is possible to move from test to treatment in 72 hours. The familiar mobile testing unit is shown as being remodeled to provide tuberculin skin testing facilities. A special results clinic bus is shown visiting testing locations three days after x-raying and skin testing. Aim of the ambitious program that works closely with physicians and health department personnel is the complete eradication of TB in Wisconsin.

S–31—BONE CHANGES THRU LIFE

C. HUGH HICKEY, MD, St. Joseph's Hospital, Milwaukee

An exhibit of x-rays and photomicrographs of bone representing the normal and abnormal changes in bone mineralization and form through the decades of life, with examples of normal and disease-induced changes will be shown.

S–32—AMERICAN CANCER SOCIETY

Wisconsin and Milwaukee Divisions

Exhibit depicts eight major types of carcinoma. Color transparencies will illustrate malignancies of the lung, kidney, colon, and cervix. Additional carcinomas in situ will be shown. The exhibit is part of the Cancer Society's continuing program of professional education and has been prepared in cooperation with various physicians throughout the state.

Technical Exhibits

28—ABBOTT LABORATORIES, North Chicago, Ill
64—AMES COMPANY, Elkhart, Ind
70—ARNAR STONE LABORATORIES, INC., Mount Prospect, Ill.
56—AUDIO DIGEST (Pacific Equip. Co.), North Hollywood, Calif.
13 & 49—AYERST LABORATORIES, Chicago, Ill.

36—BARR X-RAY CO., Milwaukee
59—BENCO OPHTHALMIC LABORATORIES, INC., Milwaukee
17—THE BORDEN COMPANY, New York City
16—BURROUGHS WELLCOME & CO., Tuckahoe, N. Y.

21—CAMERON MILLER INSTRUMENT CO., Chicago, Ill.
61—CARNATION COMPANY, Los Angeles, Calif.
30—CIBA PHARMACEUTICAL CO., Summitt, N. J
47—COCA–COLA BOTTLING COMPANY OF WISCONSIN, Milwaukee

87—D. M. DOYLE PHARMACEUTICAL COMPANY, Minneapolis, Minn.

51—EATON LABORATORIES, Norwich, N. Y.
85—ECONO LEASE OF MILWAUKEE, Milwaukee
57—ENCYCLOPAEDIA BRITANNICA, Chicago, Ill.
2—ENDO LABORATORIES, INC., Richmond Hill, N. Y.
18—MARSHALL ERDMAN & ASSOCIATES, Madison

73—A. J. FARNHAM COMPANY, INC., Milwaukee
19—H. G. FISCHER & COMPANY, Franklin Park, Ill.
38—GEIGY PHARMACEUTICALS, Yonkers, N. Y.
1—GENERAL ELECTRIC X-RAY, Milwaukee
42—GERBER PRODUCTS, Fremont, Mich.
88—GRAF'S BEVERAGES, INC., Milwaukee

62—HOFFMANN–LA ROCHE, INC., Nutley, N. J.
67, 68—HURLEY X-RAY COMPANY, Milwaukee

14—KNOLL PHARMACEUTICAL COMPANY, Orange, N. J.
4—KREMERS–URBAN COMPANY, Milwaukee

9—LAKESIDE LABORATORIES, INC., Milwaukee
65, 66—LANGER LABORATORIES, Milwaukee
3—LEDERLE LABORATORIES, Pearl River, N. Y.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa
44, 45—ELI LILLY & COMPANY, Indianapolis, Ind.
27—LOEWI & COMPANY, INC., Milwaukee
76—LOGIN BOOK CO., Chicago, Ill.
86—LOV-E BRASSIERE COMPANY, Hollywood, Calif.

37—McNEIL LABORATORIES, INC., Fort Washington, Pa.
8—MADLAND LABORATORIES, INC., Milwaukee
33—MARION LABORATORIES, INC., Kansas City, Mo.
58—MEAD JOHNSON LABORATORIES, Evansville, Ind.
43—MEDICAL PROTECTIVE CO., Fort Wayne, Ind.
S-38—MEDICO-MART, INC., Milwaukee
40, 41, 54, 55—MERCK SHARP & DOHME, West Point, Pa.
60—WM. S. MERRELL COMPANY, Cincinnati, O.
22—MILWAUKEE CONTOUR CHAIR CO., Milwaukee
63—MILWAUKEE COMPANY, Milwaukee
84—MONARCH INSURANCE CO., Madison
80—C. V. MOSBY COMPANY, St. Louis, Mo.
89—MUTUAL BENEFIT LIFE INS. CO., Madison

50—ORTHO PHARMACEUTICAL CORP., Raritan, N. J.

79—PARKE, DAVIS & CO., Detroit, Mich.
82—PENGELLY X-RAY CORP., Milwaukee
75—PFIZER LABORATORIES, New York City
31—PHYSICIANS & HOSPITALS SUPPLY CO., Minneapolis,
6—PROFESSIONAL BUSINESS SERVICE, La Crosse

78—ROEMER–KARRER COMPANY, Milwaukee
26—J. B. ROERIG & CO., New York City
53—ROSS LABORATORIES, Columbus, O.
S-37—ROWELL LABORATORIES, Baudette, Minn.

39—SANDOZ PHARMACEUTICALS, Hanover, N. J.
35—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING CORPORATION, Union, N. J.
15—G. D. SEARLE & CO., Chicago, Ill.
74—SEEFURTH & McGIVERAN, Milwaukee
23—SMITH, MILLER & PATCH, INC., New Brunswick, N. J.
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24—WARNER–CHILCOTT LABORATORIES, Morris Plains, N. J.
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12—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.
48—WHITE LABORATORIES, Kenilworth, N. J.
25—WINTHROP LABORATORIES, New York City
77—WISCONSIN 7-UP BOTTLERS ASSOCIATION, Madison

83—ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.

COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

Election of officers for 1965 featured the February 16 meeting of Ashland–Bayfield–Iron County Medical Society at The Platter in Ashland.

Dr. R. J. Sneed was chosen as president and named to office with him were *Dr. W. E. Bargholtz*, vice-president and president-elect; and *Dr. C. A. Grand*, secretary-treasurer, all of Ashland. Doctor Grand is also the society's delegate, with *Dr. J. M. Jauquet*, Ashland, as alternate. Presiding officer was *Dr. L. W. Moody*, Bayfield, outgoing president.

Guest physicians from Duluth, Minn., Douglas County, and Gogebic County in Michigan joined members of the Society for the January dinner meeting at The Platter. Doctor Moody introduced the speaker, Dr. Edmund Foley of Chicago, whose subject was "Connective Tissue Diseases."

BROWN

Dr. William P. Crowley, Jr., Madison, chief medical consultant to the Wisconsin State Board of Vocational and Adult Education, Rehabilitation Division, Disability Determination Unit, addressed the January 14 meeting of the Brown County Medical Society at the Northland Hotel in Green Bay. Doctor Crowley discussed the disability insurance program of the Social Security Administration and described the type of medical evidence required for disability evaluation. His talk was preceded by a business meeting and dinner.

CHIPPEWA

Dale Jennerjohn of the State Board of Health, Madison, discussed new nursing home regulations at the meeting of the Chippewa County Medical Society February 2 at the Hotel Northern, Chippewa Falls. Also on the program was Glenn Waldschmidt, regional representative of the State Medical Society, whose topic was "Operation Hometown."

DANE

"Comments and Kodachromes from a World Health Organization Assignment in the Far East" was the subject of *Dr. Alfred S. Evans* as speaker for the meeting of Dane County Medical Society February 9 at State Medical Society headquarters, Madison.

Doctor Evans, who is professor and chairman of the Department of Preventive Medicine, University of Wisconsin Medical School, as well as director of the State Laboratory of Hygiene, was called to the Philippines by the World Health Organization over a year ago when a disastrous epidemic of cholera was raging in Manila. He gave yeoman service to a country in which no adequate laboratory facilities were available. Since returning to this country, he has learned that the Virology Laboratory he established has become a permanent facility.

Physicians whose names appear in italics are members of the State Medical Society.

New members of the Society are *Dr. John T. McLaughlin*, 1962 graduate of the University of California Medical School at Los Angeles, who is in private practice at Sun Prairie, and *Dr. Frank L. Myers*, who received his medical degree from the State University of Iowa College of Medicine in 1957 and is currently a resident in ophthalmology at University Hospitals.

DOUGLAS

Members of the Douglas County Medical Society have added their backing to a drive for modern resuscitators for Douglas County ambulances and squad cars.

At a special meeting January 25, *Drs. James P. McGinnis* and *Milton Finn* of Superior appeared before the safety and law enforcement committees of the Douglas County Board of Supervisors to recommend a standard type of resuscitator which would simplify training of personnel in its use.

GREEN

The Green County Medical Society cooperated with the State Board of Health in setting up a histoplasmosis testing program in Monroe schools. In January, Monroe school children took consent slips home prior to participation or nonparticipation in the testing. *Dr. E. A. Zupanc*, Monroe pediatrician, and Mrs. Kathryn Etter, city nurse, set up the testing procedures.

KENOSHA

Because of cancellation of the scheduled program, Kenosha County Medical Society members held only a business session at their February 4 dinner meeting at the Elks Club in Kenosha.

MILWAUKEE

"Current Concepts in the Treatment of Cancer" was the subject of Dr. Simon Kramer as speaker for the meeting of The Medical Society of Milwaukee County March 11 at the Milwaukee Athletic Club. Doctor Kramer is professor and chairman of the Department of Radiation Therapy, Jefferson Medical College, Philadelphia.

RACINE

When members of the Racine County Medical Society met February 18 at The Hub Restaurant

in Racine, their speaker was *Dr. Philip P. Ruetz* of Milwaukee, on the subject, "Radioisotope Organ Scanning."

WALWORTH

A successful meeting, with 31 persons attending, opened the 1965 year for the Walworth County Medical Society January 21 at The Abbey, Fontana.

Guest speaker was Berwyn Braden, Lake Geneva attorney, whose theme was "Interprofessional Communications."

Members' wives were present for the dinner meeting, at which those in attendance were greeted by the Society's officers: *Dr. Richard J. Rogers*, Elkhorn, president; *Dr. William C. Woods*, Delavan, vice-president, and *Dr. E. D. Hudson*, Lake Geneva, secretary-treasurer.

Wives and guests of members also attended the Society's dinner meeting on February 18 at The Abbey. Speaker was *Dr. F. J. Ansfield*, professor of clinical oncology, University Hospitals, Madison, who discussed "Basic Chemotherapy in Cancer."

WINNEBAGO

A "cruise" for the benefit of the American Medical Association Education and Research Foundation was held February 13 for members of the Winnebago County Medical Society and their wives. Setting was the Neenah home of *Dr.* and Mrs. *R. L. Suechting*. Those attending the unusual party "disembarked" after making a cruise donation to be applied to the Foundation.

PORTAGE

STEVENS POINT DAILY JOURNAL Photo

DR. J. R. ERICKSON, Stevens Point, was installed on January 12 as president of the Portage County Medical Society. He is pictured here with the other installed officers and the society's dinner speaker, *Dr. Ovid Meyer*, Madison, a boyhood resident of Stevens Point. From left are Doctor Erickson; *Dr. J. A. Litzow*, Stevens Point, president-elect; Doctor Meyer, and *Dr. A. M. Kohn*, Stevens Point, secretary-treasurer. The installation ceremonies and Doctor Meyer's address followed a dinner at the Hot Fish Shop in Stevens Point.

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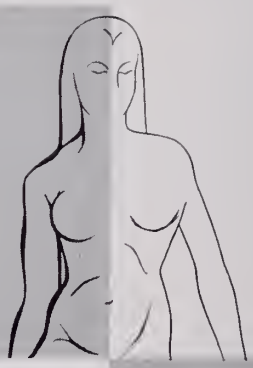

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SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

The Arthur W. Rogers Memorial Lecture was delivered by Dr. Thomas H. Holmes February 16 when the Milwaukee Academy of Medicine met at the University Club of Milwaukee. Doctor Holmes, who is professor of psychiatry at the University of Washington, spoke on the subject, "Human Ecology, Health, and Disease." Invited to the dinner meeting were members and guests of the Milwaukee Neuropsychiatric Society.

The Academy's next meeting was announced for March 16, with Dr. Thomas E. Starzl, chief of the Surgical Service, Veterans Administration Hospital, speaking on "Experience with Clinical Organ Transplantation."

MILWAUKEE JOURNAL Photo

THE MILWAUKEE ACADEMY OF MEDICINE installed new officers January 19 at the University Club in Milwaukee. Dr. C. Morrison Schroeder (center) succeeded Dr. Donald M. Ruch (left) as president, Dr. F. Jackson Stoddard is president-elect.

Wisconsin Psychiatric Association

Dr. B. Cullen Burris, Milwaukee, medical director of the Milwaukee Sanitarium Foundation, has been named president-elect of the Wisconsin Psychiatric Association for the year beginning in May. Incoming president is *Dr. Edward E. Houfek* of Sheboygan, who will succeed *Dr. Robert E. O'Connor* of Madison.

In other action taken at the annual business meeting February 6, the Association reelected *Dr. Carroll W. Osgood*, Milwaukee, to his fourth term as secretary. *Dr. Earl H. Jochimsen*, Sheboygan, was elected treasurer, and *Drs. Leigh M. Roberts*, Madison, and *Jack D. Edson*, Wales, were named as councilors. *Dr. Ervin Teplin*, Milwaukee, will be delegate to the Association of District Branches of the American Psychiatric Association and his alternate will be *Dr. Leonard J. Ganser*, Madison, director of the Division of Mental Hygiene of the Wisconsin State Board of Health.

Physicians whose names appear in italics are members of the State Medical Society.

Southwestern Chapter, WAGP

Two veteran Iowa County physicians were honored by the Wisconsin Academy of General Practice January 12 at a dinner meeting of the Southwestern Chapter at the Platteville University Student Union. *Dr. Homer D. Ludden*, Mineral Point, and *Dr. Homer H. Morton*, Dodgeville, became the first two recipients of the honor which was recently established by the Academy to recognize "aged, retired, or disabled family doctors, who have been a credit to their profession and a service to their community."

Dr. W. D. Hamlin of Mineral Point, Academy president, made the presentation. *Dr. Stanley B. Marshall* of Hollandale, president of the Iowa County Medical Society, accepted for the two physicians, who are both patients at St. Joseph's Hospital, Dodgeville.

Brown County Division, WHA

Dr. George A. Hellmuth, associate professor of occupational and environmental medicine at Marquette University School of Medicine, Milwaukee, was one of the principal speakers at a cardiac-in-industry conference held January 21 in Green Bay under the sponsorship of the Wisconsin Heart Association's Brown County Division.

Speaking on "Heart Disease and the Law—a Ten Year Study of the Wisconsin Industrial Commission," Doctor Hellmuth discussed his findings in cardiac compensation cases developed through a grant from the Wisconsin Heart Association.

Officials from industry, business, law, and government, physicians, nurses, and public health workers heard Doctor Hellmuth call for "a second look" at current compensation laws and more honest testimony from medical people who care for compensation claimants.

Fond du Lac Medical, Dental Assistants

Fond du Lac Medical and Dental Assistants held their fourth meeting of the 1964–1965 year January 14 at the Colony in Fond du Lac. Speaker was Fond du Lac internist, *Dr. H. J. McLane*, who is chairman of community service and education with the Wisconsin Heart Association. Accompanying him was Paul Dehling, WHA field representative. Films were shown on artificial resuscitation and external heart massage.

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Dosage: Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

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References: 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.*: Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.*: New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Pennepacker Joins Hospital Staffs

Drs. M. B. Llewellyn and *E. F. Sabado* announce the association of *Dr. J. S. Pennepacker* in the practice of clinical and anatomic pathology at Mercy Hospital, Janesville; Fort Atkinson Memorial Hospital, Fort Atkinson, and Memorial Community Hospital, Edgerton.

Dr. T. O. Miller Becomes Diplomate

Dr. Thomas O. Miller, Wausau orthopedic surgeon, has passed Part 2 of his orthopedic boards and is now a diplomate of the Board of Orthopedic Surgery.

Dr. Edmondson Retires

After 43 years of practicing medicine in Waukesha, *Dr. C. C. Edmondson* retired in November 1964. He arrived in that community in 1921 with a diploma from the University of Tennessee Medical School, and at the invitation of the late Dr. W. E. Nicely, joined the three-member staff of The Spa, a private hospital which treated mainly diabetic and cardiovascular patients. The hospital, Doctor Edmondson recalls, was one of the medical institutions chosen for experimental work with insulin following its discovery in 1923.

When The Spa was sold in 1940, Doctor Edmondson entered private practice in Waukesha. He has served as chief of staff at Waukesha Memorial Hospital and served on the hospital board for 10 years, and he also headed the Waukesha County Medical Society for one term.

Also a physician is his son, Dr. Robert Edmondson of Woodland, Calif.

State Doctors on NTA Committees

Serving appointments with the National Tuberculosis Association and the American Thoracic Society are *Dr. Henry A. Anderson*, Stevens Point, Wisconsin's representative councilor to the ATS; *Dr. William W. Stead*, Milwaukee, member of the editorial board of the AMERICAN REVIEW OF RESPIRATORY DISEASES; Dr. Avrum B. Organick, Milwaukee, serving on the ATS committee on therapy; *Dr. Ross C. Kory*, Milwaukee, member of its subcommittee on exhibits, and *Dr. Oscar A. Sander*, Milwaukee, ATS representative on the National Health Council.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Thompson Chief of Staff

Dr. Thomas N. Thompson, Jr., has recently been elected chief of the medical staff of Memorial Hospital at Neillsville, succeeding *Dr. Sarah D. Rosekrans.*

Janesville Doctors Speak for WHA

A group of Janesville physicians headed by Dr. Charles S. Baker donated their time to speak for the Wisconsin Heart Association during its fund-raising campaign in February. The group included *Drs. George E. Gutmann, Thomas S. Sargeant, Herbert M. Snodgrass* and *Marshall F. Purdy.*

Dr. Miezio at Winnebago

A psychiatric resident for three years at University Hospitals, Madison, *Dr. Stanley Miezio, Jr.*, has been service chief of the children's unit at Winnebago State Hospital since last fall. The unit was established July 1, 1962, with *Dr. Darold Treffert* in charge.

Dr. Effenhauser at Lake Mills

Since March 1, *Dr. Manfred Effenhauser* has been associated with *Dr. E. J. Netzow* in the practice of medicine at Lake Mills. A native of Germany, Doctor Effenhauser received his medical degree from the University of Freiburg, Germany, and in this country has interned at the Northern Westchester Hospital, Mount Kisco, N. Y., and served a residency in cardiology and internal medicine at Broward General Hospital, Fort Lauderdale, Fla. Prior to locating in Lake Mills, he practiced for two and a half years in Winneconne.

Dr. M. G. Peterson, with whom Doctor Netzow has practiced since 1947, is retiring April 1.

Milwaukee Doctors Made Fellows

Four Milwaukee physicians, *Drs. John L. Armbruster, Robert W. Byrne, Abraham Melamed,* and *Hobart H. Wright*, were among the 42 radiologists who were made fellows of the American College of Radiology at the group's annual meeting February 9–13 in Philadelphia.

Lisbon Clinic Plans Announced

Construction is scheduled to get underway this spring on a new clinic building in New Lisbon, according to plans announced early in February by *Drs. C. L. Weston* and *Charles B. Koch* of the Koch–Weston Clinic.

Dr. Pellicer Joins Peace Corps

Dr. Joseph G. Pellicer, New Holstein, left late in February to spend two years in Rabat, Morocco, on a Peace Corps assignment. His wife and six children accompanied him.

Pathology Diplomates

Recently certified as diplomates of the American Board of Pathology were *Drs. Jordon Frank*, Beloit;

Alfred Meyers and Sam D. Varma, Milwaukee, and *Robert D. Neubecker*, Marshfield.

Dr. Hartzler at Grantsburg

Dr. Paul L. Hartzler joined the medical staff of the Grantsburg Hospital and Clinic in January. A graduate of Ohio State University at Columbus, Doctor Hartzler interned at Toledo Hospital, Toledo, O., and had practiced at Swanton, O., before coming to Grantsburg.

Dr. Nellen Named Regent

Dr. James W. Nellen, Green Bay orthopedic surgeon and staff physician of the Green Bay Packers, on February 1 was named to a nine-year term on the University of Wisconsin Board of Regents by Gov. Warren P. Knowles.

The week following Doctor Nellen's appointment, Governor Knowles named Whitewater physician, *Dr. Stephen H. Ambrose*, to the State Universities Board of Regents for a term expiring in February 1967.

Dr. Flaherty Awarded Fellowship

Dr. Timothy T. Flaherty, resident in radiology at University Hospitals, Madison, is the recipient of a clinical fellowship awarded by the American Cancer Society. Announcement of the award was made by *Dr. Glenn A. Smiley*, Delavan, president of the Wisconsin Division, American Cancer Society. Carrying a stipend of $3,600, the fellowship was awarded to the University of Wisconsin, which in turn appointed Doctor Flaherty.

Dr. Von Gradulewski at Watertown

Dr. Margaret A. Von Gradulewski is now practicing at Watertown. The German-born and trained physician and surgeon had practiced at Necedah prior to locating in Watertown in mid-December.

110 Persons Fete Dr. Campbell

A testimonial banquet honoring *Dr. William B. Campbell*, 86, for his 65 years of service as a general practitioner was held January 20 in Waukesha. Sponsored by the Tri-County Chapter of the Wisconsin Academy of General Practice, the dinner was attended by 110 persons from the medical community.

Photo courtesy WAUKESHA DAILY FREEMAN

HONORING *DR. WILLIAM B. CAMPBELL*, Waukesha, a dinner party was held January 20 at the Avalon Motor Hotel in Waukesha. With Doctar Campbell are, fram left to right, Miss Agnes Barr, New Berlin; Miss Elizabeth Demochitz, Waukesha, the doctar's secretary far 45 years, and *Dr. Richard K. Chambers*, Hartland, wha presented Dactar Campbell with a certificate in recognition af his service to the community and the medical prafession.

Doctor Campbell practiced for 18 years in Menomonee Falls and served for a year in the Army Medical Corps before locating in Waukesha in 1918. He was chief of staff at Waukesha Memorial Hospital and also chief of surgery.

Doctor Campbell was an early member of the Waukesha County Medical Society. He became a member of the State Medical Society 50-Year Club in 1949 and a life member in 1951. Among the other organizations to which he belongs is the Milwaukee Academy of Medicine.

Also a physician is one of Doctor Campbell's three sons, *Dr. P. E. Campbell*, Waukesha.

Dr. Standard Featured

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practice in the state, according to a feature story in the February 7 edition of THE MILWAUKEE JOURNAL magazine section. The story's title, "ANNA STANDARD: Center of a Cyclone," is based on the fact that every working day Doctor Standard's orderly waiting room is turned into "a cluttered play pen" by the dozens of children who visit her.

Doctor Standard's father, Dr. Edgar Thomas, now semiretired, has been practicing in Milwaukee for about 40 years.

Dr. Herrmann Promoted

Since February 1, Dr. Anthony A. Herrmann has been serving as medical director for the Oak Creek and Milwaukee operations of AC Spark Plug Division of General Motors. He replaced *Dr. Merrill P. Benoit*, who was named medical director of Pontiac Motor division, Pontiac, Mich. Prior to his promotion, Doctor Herrmann was associate medical director at AC, which he joined in October 1962 as plant physician.

Dr. Buerki Retires

Dr. Robin C. Buerki, one of the driving forces behind the organization and development of University of Wisconsin Hospitals, Madison, retired January 1 as director of Henry Ford Hospital, Detroit. He is continuing as a consultant and member of the hospital board of trustees. In 1964, Doctor Buerki was given a Gold Medal Award for Excellence in Hospital Administration, a recognition newly established by the American College of Hospital Administrators.

New Hospital at Whitehall

Two of the physicians on the staff of Whitehall's first hospital are still on the board of directors of the new Tri-County Memorial Hospital which opened February 14 in Whitehall. They are *Dr. N. S. Simons*, also on the staff as an eye, ear, nose, and throat specialist, and *Dr. R. L. MacCornack Sr.*, now retired.

Also on the medical staff are *Drs. O. M. Schneider*, Blair; *C. F. Meyer*, Independence; *Larry L. Hanley*, Whitehall; Joseph Tschetter, Whitehall, eye, ear, nose, and throat specialist; *J. B. Dibble* and *Ralph Hudson*, Eau Claire, surgeons; and *H. C. Huston*, *T. D. Moberg*, and *Emil Schulz*, Eau Claire, visiting radiologists.

New ACOG Fellows

Dr. Paul E. Carroll, Waukesha, and *Dr. Dorothy M. Barbo* of the Marquette University School of Medicine Department of Obstetrics and Gynecology, Milwaukee, will be installed as fellows of The American College of Obstetricians and Gynecologists at its annual meeting April 4–8 in San Francisco.

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Photo courtesy OSHKOSH NORTHWESTERN

DR. F. GREGORY CONNELL, son of two physicians and father of another, posed for this 90th birthday picture at his home in Oshkosh. Nothing special was planned for the anniversary on January 12 but on the preceding Sunday Doctor Connell had his family with him, including his daughter, Dr. Jane Connell Card of San Francisco, and her husband, Dr. John F. Card.

Dr. Connell Is 90

A retired Oshkosh doctor whose career as a surgeon, educator, and author brought him international renown in surgical circles celebrated his 90th birthday January 12. He is *Dr. F. Gregory Connell*, who invented the world-famed Connell suture and performed the first fundusectomy for the cure of peptic ulcer.

A former adjunct professor of surgery at the University of Illinois College of Medicine, and later preceptor at the University of Wisconsin Medical School, Doctor Connell was active in many organizations during his long career. He was the first president of the Wisconsin Surgical Society, president of the Winnebago County Medical Society in 1920–1921, and president of the State Medical Society of Wisconsin in 1923. From 1921 to 1931 he was a councilor in the State Society, in which he has held life membership since 1949. He is also a member of the 50-Year Club. From 1921 to 1934 he was alternate delegate to the American Medical Association, and he is also a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and a member of the Western Surgical Association, the National Gastro-Enterological Association, and the International and Southern Surgical Associations.

From its beginning he was a consulting surgeon at Theda Clark Hospital, Neenah, and he was also attending surgeon at St. Mary's and Mercy Hospitals in Oshkosh and consulting surgeon at Winnebago State Hospital.

Dr. Myers Wins Award

To Dr. Maurice E. Myers of Durand has been issued a Sheard–Sanford award for meritorious research in pathology, one of only 10 such granted annually in the United States. Doctor Myers earned the citation as the result of a senior medical student experiment on enzymatic activities of mitochondria after freezing and freeze drying. He and his associate conducted their work in the Department of Pathology at Marquette University School of Medicine, Milwaukee.

Wausau Clinic Has Open House

The new Stahmer Clinic in Wausau was opened to the public for tours and inspection in mid-December. Serving on the medical staff of the clinic, which had been in operation since last June, are *Drs. A. H. Stahmer, K. H. Stahmer, W. B. Rudy, D. M. Nowinski*, and *J. L. Struthers*.

Dr. Emanuel Heads Foundation

Dr. Dean A. Emanuel was named president of the Marshfield Clinic Foundation for Medical Research and Education at the annual meeting Jan. 26 at the clinic. He succeeds *Dr. Stephan Epstein*.

Dr. F. N. Lohrenz was named to succeed himself on the board of directors and he was also chosen as secretary. *Dr. R. F. Lewis, Jr.*, nominating committee chairman, announced the nominations of *Drs. W. V. Dovenbarger, J. W. Manier*, and *G. H. Williams* to succeed *Dr. L. L. Schloesser* and Doctors Epstein and Lewis on the board of directors. They were unanimously elected.

Dr. Neupert Honored

Dr. Carl N. Neupert, Madison, Wisconsin state health officer, was honored late in 1964 with the annual McCormick award presented by the Association of State and Territorial Health Officers. The recipient must have 25 years or more in public health with at least 10 years as a state health officer.

Doctor Neupert, who submitted his resignation as state health officer last fall, will be succeeded on June 1 by *Dr. E. H. Jorris*, Madison, present assistant state health officer.

Dr. de Arteaga Coming to Brillion

Dr. Julio De Arteaga is expected to open a practice in early April in the medical section of the Brillion Clinic, ending Brillion's 18-month search for a doctor. Doctor de Arteaga, who received his medical degree from the University of Salamanca

in Spain, has been a general practitioner for the last six years under a government program in Puerto Rico. He is a native of New York City.

Dr. Cromer Chief of Staff

Dr. R. W. Cromer, Antigo physician since 1954, is the new president of the medical staff at Langlade County Memorial Hosiptal, Antigo. Other officers elected at a recent staff meeting are *Dr. D. W. Dailey,* Elcho, vice-president, and *Dr. T. C. Fox,* Antigo, secretary.

Dr. Bowers Writes Book

Dr. John Z. Bowers, former dean of the University of Wisconsin Medical School, is the author of a book published in February by Harper's under the title, "Medical Education in Japan." The book is the result of material gathered by Doctor Bowers for two years for the Rockefeller Foundation.

The first of the year, Doctor Bowers took over as president of the Macy Foundation of New York, which is engaged in medical education and research. His family plan to remain at their home in Madison until September.

Edgerton Doctors in New Offices

Drs. David Cohen and *Thomas Shearer* have moved into their new quarters in Edgerton's recently completed Medical Arts Building.

Dr. Schwab at Frederic

Dr. Donald F. Schwab began practice as an associate at Frederic Clinic the first week in December. A 1961 graduate of the University of Wisconsin Medical School, Doctor Schwab had practiced in the Madison area and more recently in a clinic at Wisconsin Dells prior to locating in Frederic.

SUMMER CAMP FOR DIABETIC CHILDREN

The SUMMER CAMP for diabetic children will be conducted for the seventeenth year under the auspices of the Diabetes Association of Greater Chicago from July 18 through August 8, 1965, at Holiday Home, Lake Geneva, Wis. Boys and girls from 8 through 14 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians, and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for SUMMER CAMP are arranged in accordance with individual circumstances. Applications may be obtained from, and inquiries should be directed to: Diabetes Association of Greater Chicago, 620 North Michigan Avenue, Chicago 11, Ill., Superior 7–8842.

Dr. Quandt New Chief of Staff

Dr. C. E. Quandt, Jefferson, is the new chief of staff at Fort Atkinson Memorial Hospital succeeding *Dr. O. H. Hanson,* Fort Atkinson. Elected with him were *Dr. George Nemec,* Cambridge, vice-chief of staff succeeding *Dr. S. H. Ambrose,* Whitewater; and *Dr. H. W. Aufderhaar,* Fort Atkinson, secretary-treasurer succeeding Doctor Quandt.

Dr. Roemhild at Appleton

Dr. Joseph L. Benton, Appleton, announces the association, effective March 1, of *Dr. Franklin N. Roemhild,* formerly of Barron.

OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the October 1963 and May 1964 sessions of the House of Delegates, are being published in the February and March, 1965, issues of the WISCONSIN MEDICAL JOURNAL.

Constitutional Amendment Introduced in October 1963 for Action in May 1965

Resolved, That Article VIII, Section 3, of the Constitution of The State Medical Society of Wisconsin be amended by striking out the present Section 3 of Article VIII and substituting the following Section:

"SECTION 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called."

Constitutional Amendment Introduced in May 1964 for action in May 1965

Resolved, That no individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and that no more than a total of six terms of service as councilor shall be permitted; and be it further

Resolved, That the above provision be inserted in Section 2, Article IX, of the Constitution.

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OBITUARIES

Dr. William D. Stovall, Jr., died Oct. 18, 1964, at the age of 48.

A native of Madison who received his medical degree from the University of Wisconsin Medical School, Doctor Stovall served his internship at the U.S. Naval Hospital, Oakland, Calif. He was commissioned in 1942, called to active duty in the Navy in May 1943, and discharged in April 1949 as a lieutenant, junior grade, following foreign service.

At the time of his death, Doctor Stovall was a staff physician at Bower Hospital, medical section of Manteno State Hospital, Manteno, Ill. He had been in private practice at Monticello before accepting the Manteno post, and before locating in Monticello he practiced for six years at Brodhead. He was a former member of the Green County Medical Society and the State Medical Society of Wisconsin.

Doctor Stovall was a son of Dr. William D. Stovall, Sr., Madison. Other survivors are his widow, Patricia; two stepsons, William Gary Stovall, Miami, Fla., and James R. Stovall, with the Armed Forces in Korea; and two daughters, Tamara and Victoria, Madison.

Dr. Samuel B. Pessin, director of laboratories at St. Mary's Hospital and associate professor of pathology at Marquette University School of Medicine, Milwaukee, died Nov. 9, 1964, in Milwaukee at the age of 64.

Born in 1900 in Russia, he was brought to Oelwein, Iowa, by his family in 1909. A graduate of Marquette University School of Medicine, he served both his internship and residency at Milwaukee County Hospital.

From 1931 to 1945 he was senior pathologist at the State Laboratory of Hygiene, University of Wisconsin, and director of laboratories at St. Mary's Hospital, Madison. He had also served at one time as pathologist at Mercy Hospital, Janesville, and St. Mary's Hospital, Watertown.

Doctor Pessin was a reserve commander in the United States Public Health Service, chairman of the hematology seminar group at Marquette, past president of the Wisconsin Society of Pathologists, and a member of the College of American Pathologists, the American Society of Clinical Pathologists, the American Association of Pathologists and Bacteriologists, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. He was a diplomate of the American Board of Pathology.

He is survived by his widow, Goldie; a son, Dr. James I., New York City, and a brother, Dr. Joseph, Los Angeles.

Dr. Lawrence J. Unterholzner, 62, a Blanchardville physician since 1930, died Nov. 12, 1964, at his home in Blanchardville.

A native of Sauk County, he was a graduate of Marquette University School of Medicine and interned for a year at Madison General Hospital. After finishing his internship, he assisted Dr. Carl Andrew at Platteville for a year, going on from that community to Blanchardville, where he was practicing at the time of his death.

He was a member of the Lafayette County Medical Society, which he had served in the capacity of both secretary-treasurer and president, and of the State Medical Society of Wisconsin and the American Medical Association. He had served as public health officer for Blanchardville for 30 years, and had been active in several health organizations.

Survivors include his widow, Muriel; a daughter, Mrs. Robert McLean, Wooddale, Ill.; and three sons, Lawrence A., New Berlin; Frank, a student at Platteville; and Timothy, at home.

Dr. Jerome A. Megna, Milwaukee physician, died Nov. 13, 1964, at the age of 52.

Born in Milwaukee, Doctor Megna attended Harvard College, Cambridge, Mass., and Rush Medical College, Chicago, where he received his medical degree in 1934. He interned at Tampa Municipal Hospital, Tampa, Fla., attended graduate school for a year at the University of Pennsylvania, and served a two-year residency at Presbyterian Hospital, Philadelphia. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American College of Surgeons. He also held membership in the Santa Clara Medical Society, San Jose, Calif.

Survivors include two children, Anne and Jerome Megna, Miami, Fla.

Dr. Wendell H. Marsden, 65, died at his home in Madison Nov. 29, 1964.

Doctor Marsden was granted his M.D. degree in 1927 by the University of Wisconsin Medical School, interned at Wisconsin General Hospital, Madison, and served a residency at Augustana Hospital, Chicago.

He was a fellow of the American College of Surgeons and a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Esther; and five daughters, Mrs. John Hahn and Mrs. Tom Corbett, Madison; Mrs. Don Zugschwerdt, Kankakee, Ill.; and Mary Anne and Dorothy, at home.

Dr. William J. Frawley, Appleton eye, ear, nose and throat specialist, died at his home in Appleton, Dec. 4, 1964, at the age of 72.

A native of Chilton, Doctor Frawley attended Marquette University for three years, from 1911 through 1913. He was prominent in athletics, especially on the varsity football teams of those years. In 1915 he graduated from the Chicago College of Medicine and Surgery Medical School and served his internship at Cook County and Alexian Brothers,

Chicago, Ill. His residency was served at Chicago Ear, Nose and Throat Hospital. During World War I, he served as a captain in the Medical Corps with the 42nd Division.

Doctor Frawley was a past president and secretary of the Outagamie County Medical Society and a member, also, of the State Medical Society of Wisconsin, the American Medical Association and the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology. He was a member of the staff and served on the governing board of St. Elizabeth Hospital, Appleton, and Appleton Memorial Hospital and was also on the courtesy staff of Theda Clark Hospital, Neenah, and the New London and Clintonville Hospitals.

Survivors include his widow, Ruth; one daughter, Mrs. Joseph Osten; two sons, Thomas, Appleton, and Patrick, Madison; and a brother, Dr. D. D. Frawley, Wauwatosa.

Dr. Jacob F. Henken, a Racine physician for 44 years, died at the age of 71 Dec. 7, 1964, in Racine.

Doctor Henken was a member and former president of the Racine County Medical Society, a member of the State Medical Society of Wisconsin and the American Medical Association, a charter member and past president of the Wisconsin Urological Society, and a member, also, of the North Central Section of the American Urological Association.

He had served on Racine County Selective Service Board No. 2 and had been in charge of the state venereal disease clinic at Racine.

Born in Racine, Doctor Henken received his medical education from the University of Wisconsin and from Rush Medical College, Chicago, Ill., winning his medical degree from the latter school in 1918. He interned at St. Luke's Hospital, Chicago. In 1915, he became a charter member of Phi Beta Pi national medical fraternity.

Doctor Henken is survived by his widow, Ethel; one son, Dr. William F. Henken, Racine; and one daughter, Mrs. Earl Bell, Washington, D.C.

Dr. Norman E. McBeath, who retired in 1961 after 50 years as a physician, died Dec. 11, 1964, in Milwaukee at the age of 79.

Doctor McBeath, who practiced in Milwaukee from 1924 until his retirement, was a native of Waukesha County. He received his medical degree from Marquette University School of Medicine in 1912. Before locating in Milwaukee he had practiced in Livingston, from 1912 to 1916, and in Cassadaga, N.Y., from 1919 to 1924. He was a veteran of active service with the Army Medical Corps from December 1916 until May 1919.

An obstetrician and gynecologist, he was proclaimed the champion baby doctor of Milwaukee County in 1933 when statistics compiled by the county clerk showed that he had delivered 598 babies between June 1, 1932, and June 1, 1933.

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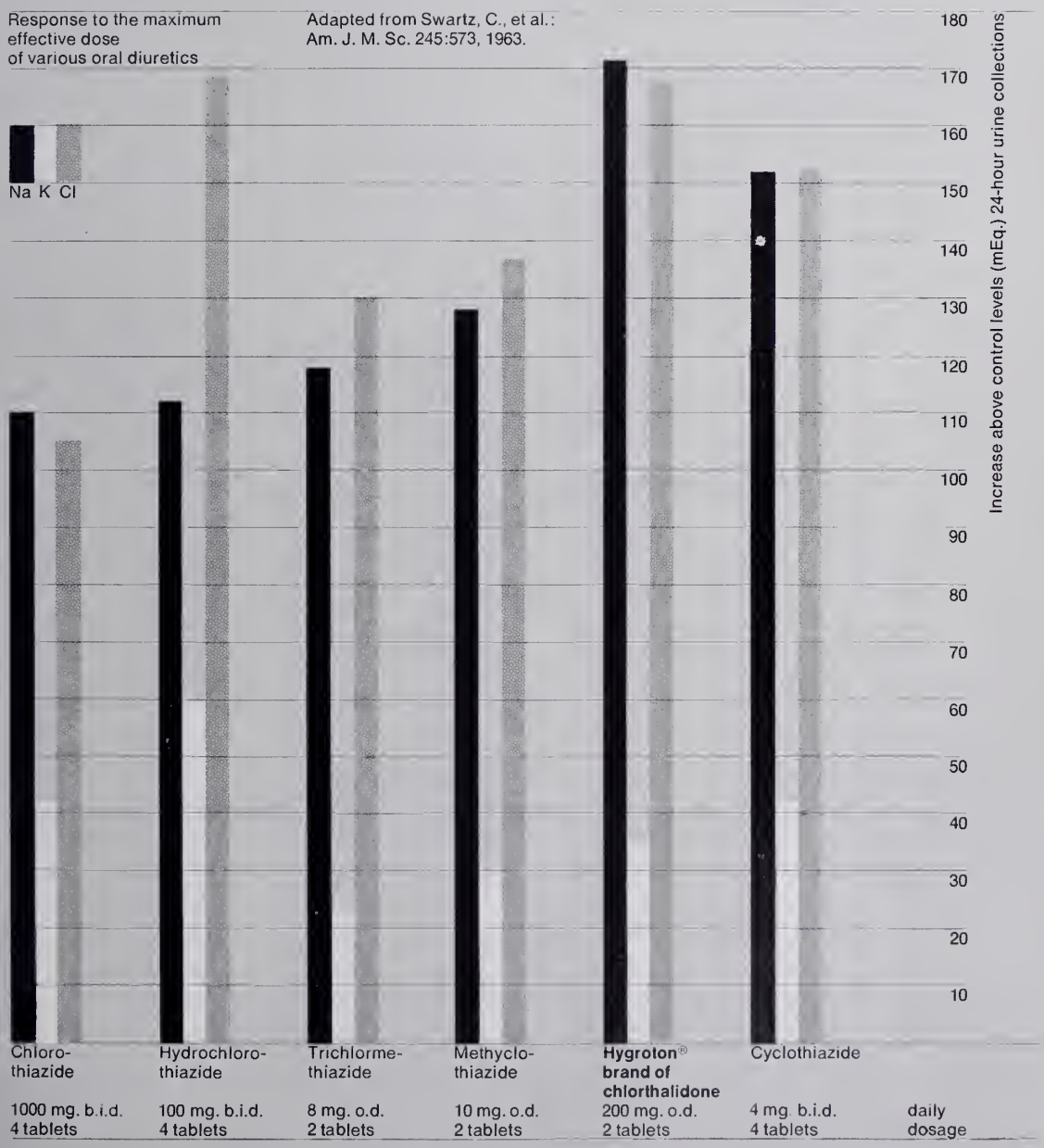

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OBITUARIES *continued*

Doctor McBeath taught obstetrics for a time at Marquette. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He had served on the staff of St. Anthony Hospital and the visiting staffs of Columbia and St. Joseph hospitals, Milwaukee.

Among his survivors are his widow, Wilma; a daughter, Mrs. Gordon Piehl, Hartland; and two sons, Donald, Cadillac, Mich., and Robert, Waterford.

Dr. Bernhard Kaufman, 49, a child psychiatrist and psychiatric consultant to the Milwaukee public schools and several social agencies, died Dec. 17, 1964, in Milwaukee.

After receiving his M.D. in 1941 from George Washington University, Washington, D.C., Doctor Kaufman interned at Touro Infirmary, New Orleans, La. His residency was served at Elgin State Hospital, Elgin, Ill., following a period of three-and-a-half years with the Army Medical Corps in the European Theater. He was an instructor at the Institute of Juvenile Research at the University of Illinois Hospitals, Chicago, until 1952 when he moved to Wisconsin.

Doctor Kaufman was a diplomate of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association, the American Orthopsychiatric Association, American Academy of Child Psychiatry, the Milwaukee Neuropsychiatric Society, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Survivors include his widow, Dorothy, and three daughters, Kathy, Marsha, and Becky, at home.

Dr. Raymond J. Groves, who just finished his 50th year as a Lodi physician, died on his 78th birthday Dec. 23, 1964.

A native of Illinois, Doctor Groves was a graduate of Chicago College of Medicine and Surgery, Chicago, Ill. (now Loyola University), and served his internship at Madison General Hospital, Madison.

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*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

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Burns, infected	331	307
Carbuncles and furuncles	125	122
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Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
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Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87]
In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded to Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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AMINOACETIC ACID (Glycine)

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INDICATIONS: Poor circulation causing cold hands and feet or pain on walking. For the more serious peripheral vascular disturbances such as . . . Raynaud's Disease, Meniere's Syndrome, intermittent claudication, diabetes, post-phlebitis syndrome, leg ulcers due to venostasis and chronic thrombophlebitis.

DOSAGE: 1 or 2 teaspoonfuls or 1 or 2 tablets 3 times a day before meals. The feeling of warmth and tingling of the skin is a desirable effect. If this reaction is too pronounced reduce dosage.

CONTRAINDICATIONS: There are no known contraindications.

FORMULA: Each teaspoonful (5ml.) elixir or each chew-tab contains:

Nicotinic Acid ..... 75 mg.
Aminoacetic Acid (Glycine) . . .750 mg.

SUPPLIED: 8 oz. bottles and bottles of 100 chew-tabs.

REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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OBITUARIES *continued*

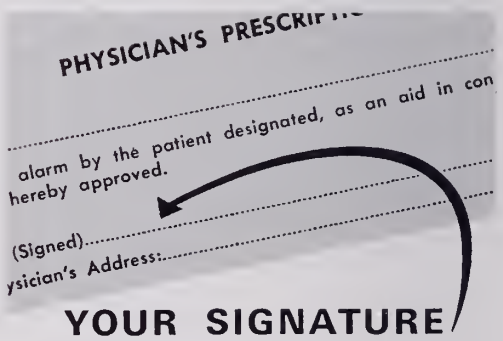
He was a member of the Columbia County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

In May of 1964, he was one of 12 doctors honored by the State Medical Society, at a dinner held in Milwaukee, for reaching the half-century mark in the medical profession.

Doctor Groves was the recipient of numerous certificates of honor and was awarded the Selective Service Medal and Certificate by Congress and signed by former President Truman. The awards were for meritorious service during his 11 years as Selective Service physician and examiner from 1943 to 1954. He also received a Certificate of Meritorious Service from the State of Wisconsin for his Selective Service work. Received after his death was a Certificate of Appreciation in grateful recognition of 20 years of service to the nation as an uncompensated member of the Selective Service system. The certificate was awarded at Washington, D.C., and signed by Lyndon B. Johnson, President of the United States, and John W. Reynolds, Governor of Wisconsin, on July 31, 1964.

Worthy of attention is Doctor Groves' steadfast loyalty to Lodi community.

Survivors include his widow, Eva, and a daughter, Pauline, at home.



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MEMBERSHIP REPORT AS OF JANUARY 15, 1965

NEW MEMBERS

David C. Angell, Sacred Heart Hospital, Eau Claire.
Michael W. Bachhuber, 410 Short Street, Mayville.
Franklyn T. Bergmann, 139½ South Main Street, Shawano.
James H. Brandenburg, 1300 University Avenue, Madison.
Robert E. Carlovsky, St. Joseph's Hospital, Marshfield.
Donald F. Cohill, 402 South Weed Street, Shawano.
Burton C. Dyson, Medical Arts Building, Wausau.
Kenneth R. Fick, 11934 West Hayes Avenue, West Allis.
Harold L. Gerndt, Jr., 601 Reed Avenue, Manitowoc.
Abraham G. Gotman, 4451 North 91st Street, Milwaukee.
Robert M. Green, 1836 South Avenue, LaCrosse.
James A. Heck, 6219 22nd Avenue, Kenosha.
Gerald J. Holmen, 510½ Oak Street, Baraboo.
Stephen B. Hull, 345 North Madison Street, Waupun.
Albert M. Kinkella, 630 South Central Avenue, Marshfield.
Gerald H. Klomberg, 124½ Front Street, Beaver Dam.
Erling A. Kloppedal, 590 Fourth Street, Prairie du Sac.
Erwin F. Koenig, 301 Troy Drive, Madison.
Gordon E. Kronquist, 500 West Milwaukee Street, Janesville.
Edward B. Miner, 1836 South Avenue, La Crosse.
Roger D. Natwick, 103 First Avenue West, Menomonie.
Thomas C. Pagedas, 8410 West Cleveland Avenue, Milwaukee.
Roland A. Pattillo, 8700 West Wisconsin Avenue, Milwaukee.
Luther W. Pearce, Box 290, Elkhorn.
Richard L. Pyle, Box 431, Waupun.
Edward H. Regehr, Athens Medical Center, Athens.
Alvin L. Smith, 2900 West Oklahoma Avenue, Milwaukee.
Clifford H. Starr, 1011 Third Street South, Wisconsin Rapids.
Eugene W. Till, 4602 South Packard Avenue, Cudahy.
Dudley E. Wilkinson, Mondovi.
Raymond J. Winkler, Tigerton.
Waldemar W. Wolfmeyer, 1015 West Wisconsin Avenue, Kaukauna.
Philip A. Zlatnik, 2219 Garfield, Two Rivers.

REINSTATED

Robert G. Love, 505 South Beaumont Road, Prairie du Chien.

CHANGES OF ADDRESS

Robert T. Adlam, 2266 North Prospect, Milwaukee.
Angelina S. Allen, Madison, to c/o Capt. M. L. Allen, A03167375, USAF Hospital, Clark APO 74, San Francisco, Calif.
Luca Alverno, 1230 West Grant Street, Milwaukee.
John Arkins, 8700 West Wisconsin Avenue, Milwaukee.
Frank Balistreri, Hinsdale, Ill., to 2400 West Villard Avenue, Milwaukee.
Rudolph Balzer, Milwaukee, to 9531 South Howell Avenue, Oak Creek.
James Berg, Milwaukee, to 10691 West Parnell Avenue, Hales Corners.
V. M. Bernhard, Milwaukee, to Baylor University College of Medicine, Houston 25, Tex.

SOCIETY RECORDS

Sheldon L. Burchman, 400 West Silver Spring Drive, Milwaukee.
Roger A. Cutshall, Grantsburg, to 10703 27th Avenue South, Burnsville, Minn.
Chalmer Davee, Columbia, S.C., to V. A. Hospital, Phoenix, Ariz.
Martin J. Denio, Jr., 1735 Wedgwood West, Box 546, Elm Grove.
Arnold N. Elconin, 945 North 12th Street, Milwaukee.
John G. Frisch, 2613 East Shorewood, Milwaukee.
John A. Gerdes, Rothschild, 6712 Hubbard Avenue, Middleton.
Lance G. Glasson, Reedsburg, to 300 Spring Street, Fox Lake.
Frank F. Gollin, Middleton, to 1300 University Avenue, Madison.
Roger B. Goodfriend, Yorktown Heights, N.Y., to 90 Westmoreland, White Plains, N.Y.
Donald C. Hampel, 2200 West Kilbourn Avenue, Milwaukee.
Clinton K. Higgins, La Crosse, to 11082 Wylestone, St. Louis, Mo.
Guy W. Holmes, Marinette, to Medical Arts Building, Wausau.
Leslie E. Jones, Racine, to Saint Agnes Hospital, Fond du Lac.
Robert M. Kass, Wausau, to Midelfart Clinic, Eau Claire.
C. A. Klasinski, Milwaukee, to 3151 Donna, Warren, Mich.
Robert G. Knight, 222 North Walnut Street, Reedsburg.
James M. Lee, 225 West Dickenson Street, San Diego.
George Light, Iowa City, Ia., to 5254 Teutonia Avenue, Milwaukee.
Richard Lindgren, Rm. 518, 110 East Main Street, Madison.
Gisela M. Meloy, 161 West Wisconsin Avenue, Milwaukee.
Joanna R. Miller, Racine, to 10 Stilt Street, New Orleans, La.
G. F. Mueller, Jr., 430 East Longview Avenue, Appleton.
John G. Noble, Monroe, to 14 Cantlon Crescent, Saskatoon, Saskatchewan, Canada.
M. G. Peterman, Washington, D.C., to 2000 South Eads Street, Arlington, Va.
L. M. Pippin, 1313 West Seminary Street, Richland Center.
Carlton J. Ryan, V. A. Building, Apt. 3, Tomah.
Donald F. Schwab, Madison, to Frederic Clinic, Frederic.
John J. Sevenants, 619 Exchange Building, LaCrosse.
James A. Sisk, 566 Fifth Street, Fond du Lac.
Ernest V. Stadel, 222 North Walnut Street, Reedsburg.
John F. Stageman, Grantsburg, to 7128 West Wedgewood Drive, Milwaukee.
Leander P. Stamm, 800 East Chateau Place, Milwaukee.
Francis J. Thornton, Milwaukee, to 1954 Atlantic Avenue, Long Beach, Calif.
Margaret A. Von Gradulewski, Necedah, to 311½ Main Street, Watertown.

Recent Wisconsin Licentiates

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, January 13, 1965.

Name	*School of Graduation*	*Year*	*City*
Adam, Alan B.	U. of Colorado	1938	Milwaukee, Wisconsin
Boberg, Arthur R.	Indiana Univ.	1961	West Allis, Wisconsin
Bruce, Charles H.	Med. Col. of Ga.	1948	La Crosse, Wisconsin
Christopher, Chris C.	U. of Athens	1952	Downey, Illinois
Chrzan, Donald J.	Marquette Univ.	1957	Colorado Springs, Colo.
Clothier, W. J. Kilburn, Jr.	Geo. Washington U.	1963	Richmond, Virginia
de Arteaga, Julio	Salamanca Sch. of Medicine	1958	Aibonito, Puerto Rico
Denenberg, Marshall I.	U. of Nebraska	1961	Madison, Wisconsin
Dumler, Larry J.	U. of Colorado	1963	Wauwatosa, Wisconsin
Gorrell, John E.	Northwestern Univ.	1930	Milwaukee, Wisconsin
Graven, Stanley N.	U. of Iowa	1956	Madison, Wisconsin
Hartzler, Paul L.	Ohio State Univ.	1961	Swanton, Ohio
Henderson, Darrell L.	U. of Tennessee	1959	Milwaukee, Wisconsin
Huffer, James M.	U. of Chicago	1958	Rochester, New York
Kohlheim, Walter R.	Temple University	1946	Parkersburg, W. Va.
Martin, C. Edwin	U. of Pennsylvania	1963	Madison, Wisconsin
Mueller, Gustave C. E.	U. of Illinois	1958	Berwyn, Illinois
Mueller, Howard A.	Boston University	1945	Janesville, Wisconsin
Pennepacker, J. Scott	Louisiana St. Univ.	1951	Lake Charles, La.
Rush, Benjamin M.	Cairo University	1950	Wauwatosa, Wisconsin
Salama, E. M.	U. of Chicago	1943	Minneapolis, Minn.
Sponsel, Kenath H.	Northwestern Univ.	1959	Madison, Wisconsin
Uehling, David T.	U. of Buenos Aires	1960	Madison, Wisconsin
Wainstein, Luis	Harvard Medical School	1957	Madison, Wisconsin

SOCIETY RECORDS *continued*

William A. Wagner, 404 North Main Street, Oshkosh.
M. A. Warpinsky, 1203 South Military Avenue, Green Bay.
John G. Webster, Manitowoc, to 359 North Main Street, Andover, Mass.
William N. Young, 2500 West Lincoln Avenue, Milwaukee.
E. J. Zmolek, 2121 Bowen Street, Oshkosh.

REMOVED FROM MEMBERSHIP

Charles S. Baker, Rock County.
John W. Callahan, Milwaukee County, transferred to Texas.
Alan B. Cameron, Wood County.
Wilbur F. Cant, Dane County, transferred to Minnesota.
Vaughn Demergian, Dane County, transferred to California.
Joseph F. Egan, LaCrosse County.
Keith D. Epperson, Milwaukee County.
Theodore C. Erickson, Dane County.
Thomas G. Haugh, Waukesha County.
Richard F. Hearn, Washington County, removed per county secretary.
John Hogan, Ashland–Bayfield–Iron County, removed per county secretary.
Theodore L. Johnson, Milwaukee County, transferred to Minnesota.
Julius H. Kelertas, Eau Claire–Dunn–Pepin County, transferred to Michigan.
Donald M. Kinkel, Wood County.
Victor J. Kozina, Milwaukee County, resigned.
L. A. Kristensen, Barron—Washburn—Sawyer—Burnett County.
Ronald R. Kyllonen, Dane County, resigned.
Jack R. Lees, Wood County.
B. W. Lyne, Clark County.
Russell H. Miller, Jefferson County.
Ray D. Reed, Eau Claire–Dunn–Pepin County, transferred to Georgia.
Edward P. Roemer, Dane County.
Hubert W. Simonsen, Rock County.
Stephen Sipos, Kenosha County, transferred to Illinois.
Shigeo Sumida, Racine County, transferred to California.
Peter Torbey, Dane County.
Paul L. Trump, Dane County, transferred to Michigan.

DEATHS

Samuel B. Pessin, Milwaukee County, November 9, 1964.
Howard Barry, non-member, November 10, 1964.
L. J. Unterholzner, Lafayette County, November 12, 1964.
Jerome A. Megna, Milwaukee County, November 13, 1964.
Julius Blom, non-member, November 28, 1964.
Wendell H. Marsden, Dane County, November 29, 1964.
William J. Frawley, Outagamie County, December 4, 1964.
Jacob F. Henken, Racine County, December 7, 1964.
Norman E. McBeath, Milwaukee County, December 11, 1964.
E. J. Mittermeyer, non-member, December 16, 1964.
Bernhard Kaufman, Milwaukee County, December 17, 1964.
Raymond J. Groves, Columbia–Marquette–Adams County, December 23, 1964.
Joseph H. Weisberg, Douglas County, January 1, 1965.
William J. Bleckwenn, Dane County, January 6, 1965.

1965 **Wisconsin**

1965

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 1–3: University of Wisconsin Department of Pediatrics, annual postgraduate seminar, "Importance of Immune Mechanisms in Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

Apr. 3–4: Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology Spring Meeting at Sheboygan.

Apr. 5–8: National Association of Recreational Therapists, annual institute, Wisconsin Center, University of Wisconsin, Madison.

Apr. 8: Health Fads and Fallacies Conference, State Medical Society, Green Bay.

Apr. 8, 15, 22, 29: Postgraduate course in Therapy of Infectious Diseases, Marquette University School of Medicine, Milwaukee.

Apr. 14: Symposium on Anxiety, Northwest Psychiatric Clinic, Eau Claire.

Apr. 10: Endocrine Seminar, Marshfield Clinic Foundation for Medical Research and Education, Marshfield.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 10–12: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

Apr. 2–4: 21st Annual Meeting, American Society for Study of Sterility, San Francisco, Calif.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 5–8: American industrial health conference, sponsored by Industrial Medical Association and American Association of Industrial Nurses, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 6: 7th Howard Fox Memorial Lecture, New York University School of Medicine, Department of Dermatology, New York, N. Y.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

Apr 21–24: Methodist Hospital Graduate Medical Center Department of Otolaryngology, in cooperation with American Rhinologic Society, introductory course in expanded surgery of nasal septum at medical center, Indianapolis, Ind.

Apr. 22–24: Symposium on Clinical Gastroenterology, Mound Park Hospital Foundation, St. Petersburg, Fla. 33701.

Apr. 26–29: American Academy of Pediatrics, spring session, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 26–29: 36th Annual Scientific Meeting, Aerospace Medical Association, New York City.

Apr. 26–29: 14th Hahnemann Symposium, sponsored by Department of Medicine, Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia.

Apr. 26–30: American College of Physicians Postgraduate Course No. 13, Humphreys Postgraduate Center, Denison Auditorium, Denver.

Apr. 28–May 1: 9th Postgraduate course in Trauma, Chicago Committee on Trauma of American College of Surgeons, Chicago, Ill.

May 1–2: Seminar on Chronic Obstructive Lung Disease, Medical College of Georgia, Augusta, Ga.

May 10–14: ACP Course No. 14, Institute of Physical Medicine and Rehabilitation, New York.

May 14–15: Fifth Institute on Preventive Psychiatry, sponsored by University of Iowa Preventive Psychiatry Committee, University of Iowa, Iowa City.

MEDICAL MEETINGS

POSTGRADUATE COURSES

May 21–23: Tri-State meeting of Illinois, Iowa, and Wisconsin Associations of Blood Banks, Davenport, Ia.

May 24–26: ACP Course No. 15, Royal Victoria Hospital on campus of McGill University, Montreal, Que., Can.

May 25: 5th International Thyroid Conference, Rome, Italy.

May 30–June 3: Medical Library Association Annual Meeting, Philadelphia, Pa.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 7–11: ACP Course No. 16, University of Iowa, Iowa City.

June 8–11: Catholic Hospital Association of United States and Canada, golden jubilee convention, Kiel Auditorium, St. Louis, Mo.

June 14–17: American Proctologic Society, 64th annual meeting, Minneapolis, Minn.

June 16: Scientific Session of American Cancer Society, Philadelphia, Pa.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

June 20–24: American Medical Association, 114th annual convention, New York Coliseum, New York.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

July 29: 2nd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology, Vienna, Austria.

Aug. 2–6: Department of Pediatrics and Office of Postgraduate Medical Education of University of Colorado School of Medicine, 8th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 8: 8th International Anatomical Congress, Wiesbaden, Germany.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30–Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

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MEDICAL MEETINGS *continued*

1965

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Hahnemann Symposium

The 14th Hahnemann Symposium, "Mechanisms and Therapy of Cardiac Arrhythmias," will be held April 26–29 at the Sheraton Hotel, Philadelphia, Pa., under the sponsorship of the Department of Medicine, Hahnemann Medical College and Hospital. This postgraduate course is acceptable for 33 hours of AAGP credit. A registration fee of $75 should accompany the application. Interns and residents will be charged a fee of $15.

ACP Postgraduate Courses

The American College of Physicians Postgraduate Course No. 13, "Cardiopulmonary Diseases," will be presented April 26–30 at Humphreys Postgraduate Center, Denison Auditorium, Denver. The University of Colorado Medical Center, Denver, arranged the course, for which fees are $60 for members and $100 for nonmembers. Registration forms and requests for information should be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

ACP Course No. 14, "Rehabilitation," will be given May 10–14 by the New York University Medical Center, at the Institute of Physical Medicine and Rehabilitation, New York, N. Y. Course No. 15, "Current Concepts in Gastroenterology," is scheduled for May 24–26 at Royal Victoria Hospital, on the campus of McGill University, Montreal, Que., Can. June 7–11 are the dates for Course No. 16, "Basic Principles in Internal Medicine," at the University of Iowa Department of Medicine, Iowa City.

Ob-Gyn Board Part II Exam

Dr. Clyde L. Randall, secretary-treasurer of the American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, N. Y. 14216, announces that the Part II examination will be conducted by the American Board of Obstetrics and Gynecology at The Edgewater Beach Hotel, Chicago, Ill., April 26–May 1. Candidates scheduled for examination are urged to make their hotel reservations at an early date.

Applications for the Part II examination to be given in April, 1966, will be accepted in the Secretary's office during April or May, 1965, and must be accompanied by duplicate lists of patients dismissed from their service during the 12 months immediately preceding date of application.

Current bulletins outlining present requirements and application forms may be obtained by writing to the office of the Secretary.

Institute on Preventive Psychiatry

The role of the school and of community treatment facilities in carrying out procedures suggested by research to date for preventing mental illness and promoting mental health will be the subject of the Fifth Institute on Preventive Psychiatry May 14–15 at the University of Iowa, Iowa City.

Purpose of the institutes, which are sponsored by the University of Iowa Preventive Psychiatry Committee, is development of a broad perspective from which research programs and a range of meaningful individual investigations can be projected. Previous sessions have dealt with research involving factors suspected of causing mental illness or enhancing mental health. The fifth institute will be the first of several to focus on the present state of research and thinking concerning the role of different social institutions in applying the procedures for prevention of mental illness available knowledge suggests.

Tri-State Blood Bank Meeting

The Tri-State meeting of the Illinois, Iowa, and Wisconsin Associations of Blood Banks will be held May 21–23 at the Clayton House Motel, Davenport, Ia. The program will be directed toward the interests of blood bank technicians and will emphasize the practical aspects of blood banking.

Among those on the program will be Dr. Clara V. Hussey of Marquette University School of Medicine, Milwaukee, on the topic, "Treatment of Coagulation Problems with Blood Products."

Inquiries with regard to registration should go to: Mrs. Elizabeth G. Parker, Secretary–Treasurer, Iowa Association of Blood Banks, Community Blood Bank of Central Iowa, 1119 Woodland Ave., Des Moines, Ia.

Medical Library Association

The annual meeting of the Medical Library Association will be held May 30–June 3 at the Bellevue–Stratford Hotel in Philadelphia, where some of the oldest medical libraries in the United States are located.

On June 2, during the annual meeting, three one-day courses will be given to broaden the background of people working in medical libraries. Brief descriptions may be obtained from Irwin H. Pizer, SUNY Upstate Medical Center, 766 Irving Ave., Syracuse, N.Y.. 13210.

CHA Golden Jubilee

The Catholic Hospital Association of the United States and Canada will hold its Golden Jubilee convention June 8–11 at Kiel Auditorium, St. Louis, Mo. General sessions will include addresses by several distinguished men and women and there will also be special and sectional meetings and special events including a Golden Jubilee banquet.

American Proctologic Society

The 64th annual meeting of the American Proctologic Society is scheduled for June 14–17 at the Hotel Leamington, Minneapolis, Minn.

Original papers, panel discussions, and a series of instructional courses will make up the program. Topics for panel consideration are colonic and intestinal fistulas, complications of anorectal surgery, colon and rectal surgery in relationship to surgical programs of medical schools and hospitals, and "How I Do It," a presentation of techniques of operations for cancer of the rectum and colon.

AMA Announces Convention Highlights

The Council on Postgraduate Programs of the American Medical Association announces that the program for the 114th annual convention in New York City June 20–24 is virtually complete, and that an attendance of between 25,000 and 30,000 physicians is anticipated. Dr. J. Arnold Bargen, Temple, Tex., Council chairman, said the program will be most comprehensive, including lectures, scientific exhibits, preview showings of medical films, and color television.

Six general scientific meetings at the New York convention will offer to physicians the most recent findings in adverse drug reactions; organ transplantation; hearing; non-narcotic drug addiction; metabolism in growth development and aging, and diagnostic cytology. Twenty-three specialty sections also will have programs.

The convention will center in the New York Coliseum at Columbus Circle, adjoining Central Park, but some of the meetings will overflow into hotels in the midtown area. The complete program will be published in the May 10 issue of the Journal of the AMA.

According to Doctor Bargen, thousands of American physicians are planning to combine convention attendance with a trip to New York City with their families to see the New York World's Fair.

Postgraduate Course in Pediatrics

The eighth annual postgraduate course in pediatrics will be presented by the Department of Pediatrics and the Office of Postgraduate Medical Education of the University of Colorado School of Medicine August 2–6 in the Casino Building of the Stanley Hotel in Estes Park, Colo.

Subjects to be discussed include pediatric hematology, endocrinology, neurology, cardiology, allergy, metabolic diseases, gastroenterology, antibiotic therapy, genetic disorders, respiratory physiology, infectious diseases, immunization, problems of the premature and newborn infant, child guidance problems and family adjustment, and adolescent medicine.

Tuition fee is $75.

UW Surgery Course

A three-day course directed to the surgically oriented physician will be held at the University of Wisconsin's Medical Center August 26–28.

Aspects of newer measures in cardiovascular surgery, biliary tract surgery, general abdominal surgery and other current developments will be presented by a faculty from the UW Medical School augmented by guest professors, Dr. Frank Glen, Cornell University, New York; Dr. Tom Shires, University of Texas–Southwest Branch, Dallas, and Dr. Harold Laufman, Northwestern University, Chicago.

Sessions will be held in the Wisconsin Center, the University's continuing education building on the shore of Lake Mendota, and housing will be in the Towers, the campus area's newest private luxury dormitory.

Complete information may be obtained from Paul Knipping, 401 Extension Bldg., University of Wisconsin, Madison, Wis. 53706.

Blood Bankers to Meet

The 18th annual meeting of the American Association of Blood Banks will be held September 14–17 at the Americana Hotel, Bal Harbour, Fla. A preconvention technical seminar, which has become a meeting highlight, will focus on hemolytic disease. Dr. Wolf W. Zuelzer, director of the Child Research Center in Detroit, will deliver the annual Emily Cooley lecture.

Raymond Ambelang of Wauwatosa is chairman of the committee on exhibits.

Interprofessional Seminar

The University Hospital in Iowa City, Ia., will be the setting on September 16–17 for the annual West North–Central Interprofessional Seminar on Diseases Common to Animals and Man. Sponsoring the meeting are the College of Medicine of the University of Iowa, Iowa State Department of Health, College of Veterinarian Medicine of Iowa State University, and the U. S. Public Health Service. The first day of the meeting will concentrate particularly on diseases of children.

Further details of the program may be obtained from Dr. William F. McCulloch, Institute of Agricultural Medicine, University of Iowa, Iowa City.

19th World Medical Assembly

Delegates and memhers of 60 national medical associations will convene in London Septemher 19–25

for the 19th World Medical Assembly under the auspices of the British Medical Association.

The 1965 meeting promises to be one of the largest and most successful gatherings in WMA history. The initial session of the general assembly will be opened by Her Royal Highness, Princess Margaret. Distinguished British surgeon, Sir Clement Price–Thomas, will be installed WMA president at the opening session.

Theme of this year's scientific program is "Communicable Diseases and Modern Travel." Leading British medical authorities will examine aspects of the numerous health problems created by today's rapid transit.

In addition to the regular AMA delegation attending the Assembly, a large observer delegation of American physicians will participate.

In conjunction with the Assembly, the U. S. Committee's travel department is arranging a series of pre and post medical tours to other countries, with transportation by TWA jets.

Information on observer credentials, accommodations, individual and group travel, medical tours and sightseeing is available from the United States Committee, W.M.A., Columbus Circle, New York, N. Y. 10019.

Heart Association Sessions

Official dates for the American Heart Association's annual scientific sessions have been set for October 15–17 in the Americana Hotel, Bal Harbour, Fla. The sessions are held in conjunction with the Association's annual meeting which will continue through October 19. Further information and registration forms may be obtained from H. Douglas Chisholm, American Heart Association, 44 East 23rd St., New York, N. Y. 10010.

CONFERENCE ON

HEALTH FADS AND FALLACIES

Sponsored by

The State Medical Society of Wisconsin

THURSDAY, APRIL 8

Brown County Veterans Memorial Arena

GREEN BAY, WISCONSIN

The conference will feature state and national speakers on health fads and fallacies in the fields of cancer, arthritis, nutrition and those particularly affecting our older citizens. Current advertising practices and the Krebiozen controversy will also be covered.

OPEN TO THE PUBLIC

Encourage people in your community to attend this important event, and plan to attend yourself. For detailed information contact: Communications Department, State Medical Society, Box 1109, Madison.

Symposium on Coccidioidomycosis

The Second National Symposium on Coccidioidomycosis is slated for December 8–10 at the Del E. Webb TowneHouse, Phoenix, Ariz. For further information, interested individuals may contact Arizona Tuberculosis and Health Association, Inc., 733 West McDowell Rd., Phoenix, Ariz. 85007.

Community Health Services Conference

The National Commission on Community Health Services will cooperate with the National Health Council in a Conference on Community Health Services during September. The conference will be held as four consecutive regional forums in San Francisco, Chicago, Philadelphia, and Atlanta. They will consider recommendations and findings of the Commission's Task Forces and Community Action Studies. The Chicago forum is scheduled for September 15–18.

Florida Symposium on Gastroenterology

The Mound Park Hospital Foundation, with the joint sponsorship of the Department of Medical Education of the Mound Park Hospital, The Florida Institute for Continuing University Studies, the American Academy of General Practice, and the cooperation of the Medical and Research Divisions of Bay Pines V.A. Center, and Pinellas County Medical Society, announces a postgraduate course in Clinical Gastroenterology to be held April 22–24 at the Hospital, 701 Sixth Street, South, St. Petersburg, Fla. 33701. By special arrangement Fee $10. Eighteen accredited hours by the AAGP.

Seminar on Lung Disease

The Georgia Thoracic Society, Georgia Tuberculosis Association, Medical College of Georgia, and the Georgia Academy of General Practice will present a seminar on chronic obstructive lung disease May 1 and 2 at the Medical College of Georgia in Augusta.

A registration fee of $5.00 will be charged for the program, which is acceptable for seven accredited hours by the American Academy of General Practice. Information may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Ga. 30902.

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Surgical Treatment of Pulmonary Embolism

By R. D. SAUTTER, M.D. and B. R. LAWTON, M.D., Marshfield, Wisconsin

■ SINCE 1908, when Trendelenburg[1] first proposed pulmonary embolectomy for treatment of massive pulmonary embolism, approximately 30 successful cases have been reported in the world literature. In 1961 Cooley[2] reported a case in which he used cardiopulmonary bypass in performing a pulmonary embolectomy; subsequently, this modality has been employed in all successful cases.

In 1944 Homans[3] proposed inferior vena caval ligation for the prevention of fatal pulmonary emboli. This surgical procedure has undoubtedly saved many more lives than pulmonary embolectomy. Recently, many modifications of the original technique have been reported, all of which are designed to reduce the high morbidity.

The following is a report of our experiences both with pulmonary embolectomies using inflow tract occlusion or cardiopulmonary bypass, and with inferior vena caval ligation.

Clinical Material. *Pulmonary embolectomy.* —At this clinic we have attempted four pulmonary embolectomies (Table 1), of which only one was successful.[4] The first two embolectomies were attempted with normothermic inflow tract occlusion, since equipment for cardiopulmonary bypass was not available. Both of these patients died of residual emboli, the first surviving 52 hours, the second only 4 hours.

After these two consecutive failures and the difficulty encountered in removing the emboli in the successful case, we are convinced that cardiopulmonary bypass offers the best opportunity for success in pulmonary embolectomy. This modality allows sufficient time for a deliberate attack on the emboli. Successful embolectomies done before the use of cardiopulmonary bypass apparently were fortuitous in that the embolus had to be sufficiently cohesive to be completely removed in one or two pieces. In our two unsuccessful cases, large emboli were extracted and retrograde bleeding was brisk; however, at autopsy many small fragments were present in the small branches of the pulmonary artery. For this reason we feel that great time and effort must be spent to remove these emboli. The lung massage and catheter irrigation should be done deliberately and thoroughly.

The last patient in our series had a cardiac arrest following the opening of the pericardium just before cannulization. Perforation of the right ventricle during cardiac massage resulted in uncontrollable hemorrhage. We had previously noted an apparent deleterious effect on the heart on opening the pericardium, which was possibly related to overdistention of the ventricles. Peripheral cannulization with partial perfusion, as suggested by Cooley,[5] would perhaps be helpful.

From the Marshfield Clinic and Marshfield Clinic Foundation.

In the last two embolectomies in our series, preoperative pulmonary arteriograms were made. If the patient's condition is not terminal, arteriography should always precede embolectomy. This can be done without delaying the operation and with very little risk to the patient. The purpose, of course, is to prevent unnecessary thoracotomy. Arteriography is best done with a catheter in the right ventricle or pulmonary artery. Percutaneous injections too often do not yield films of diagnostic quality. If sufficient dye is injected percutaneously, the superior vena cava always obscures the right hilar structures. Although at present we do not confirm the diagnosis of pulmonary embolism with an arteriogram before caval ligation, it seems logical to contemplate such a procedure.

Inferior vena caval ligation.—We have used inferior caval ligation to prevent fatal pulmonary emboli in 12 cases. The results are summarized in Table 2. The operative technique is standard. The inferior vena cava is exposed by a muscle-splitting incision in the right flank and ligated just above the bifurcation with No. 1 catgut.

None of the patients in this series was disabled by the caval ligation. The only patient who is not ambulatory was incapacitated before the operation. The remaining patients do have minimal to moderate edema, which

TABLE 1—*Pulmonary Embolectomies Performed During 1962 and 1963*

Patients (Age and Sex)	Method of Diagnosis	Surgical Modality	Result
M.B., 39, F	Clinical	Bilateral thoracotomy with inflow tract occlusion	Died 52 hours postoperatively; postmortem examination showed residual emboli
H.I., 64, F	Clinical	Bilateral thoracotomy with inflow tract occlusion	Died 4 hours postoperatively; postmortem examination showed residual pulmonary emboli
F.H., 50, M	Pulmonary arteriogram	Bilateral thoracotomy with cardiopulmonary bypass	Survived
F.S., 84, M	Pulmonary arteriogram	Bilateral thoracotomy with cardiopulmonary bypass	Died of uncontrollable hemorrhage

TABLE 2—*Results of Vena Caval Ligation for Pulmonary Embolism*

Patients (Age)	Admitting Diagnosis	Method of Diagnosis	Result
J.R., 71	Right ureteral calculus	Clinical, plus radiographic findings on chest x-ray	Two and one-half years postoperative: swelling below knee, but ambulatory
E.S. 67	Viral pneumonia	Clinical, plus radiographic findings on chest x-ray	Two and one-half years postoperative: 1+ edema of legs; no disability or discomfort
M.B., 31	Placenta previa, Cesarean section	Clinical, plus radiographic findings on chest x-ray	One year postoperative: mild edema; wearing stockings; working
O.H., 76	Carcinoma of prostate	Clinical, plus radiographic findings on chest x-ray	Ten months postoperative: trace of edema; walking without difficulty
J.W.H., 42	Periarteritis nodosa; chronic thrombophlebitis	Lung biopsy	Ten months postoperative: trace of edema while wearing stockings; working
F.H., 50	Pulmonary embolism	Pulmonary arteriogram	Ten months postoperative: mild edema; no disability; no stockings; working
E.K., 62	Ulcer on right leg; thrombophlebitis	Clinical, plus radiographic findings on chest x-ray	Eight months postoperative: 1+ edema; wearing stockings; no disability; ulcer healed
C.S., 42	Deep vein thrombophlebitis; recurrent pulmonary emboli; lupus erythematosus	Clinical, plus radiographic findings on chest x-ray	Eight months postoperative: disabled; on cortisone for lupus; not ambulatory before caval ligation
E.G., 61	Bronchitis; chronic thrombophlebitis	Pulmonary arteriogram	Six months postoperative: 2+ edema; ache in legs, but walking
H.W., 59	Diffuse pulmonary disease	Lung biopsy and pulmonary arteriogram	Five months postoperative: previous amputation of right leg; only right common iliac artery ligated; much improved; no disability from ligation
W.E., 62	Carcinoma of rectum	Clinical, plus radiographic findings on chest x-ray	Four months postoperative: 2+ edema; ambulatory; dying of metastasis
J.P., 29	Pleuropericarditis	Pulmonary arteriogram	Ten months postoperative: mild edema; no disability; stockings unnecessary; working

is controlled with elastic wrappings or stockings. None of these patients is incapacitated and all are fairly comfortable. Patient M. B., a nurse, is at present doing full-time, general-duty work. Patient E. K. had a varicose ulcer which healed following caval ligation.

We have not experienced the high morbidity reported by many other authors who have used caval ligation, and there have been no operative deaths or deaths from recurrent emboli. For these reasons we believe caval ligation is the procedure of choice for the prevention of recurrent pulmonary emboli.

Summary and Conclusions. In the past three years we have taken an aggressive attitude toward the treatment of pulmonary embolism. Although our experience is somewhat limited, we have formed fairly definite concepts of how we prefer to treat this condition, and we make the following recommendations:

1. Ligation of the inferior vena cava should be performed in most cases whenever the diagnosis of pulmonary embolism is established.
2. Unless the patient is in extremis, pulmonary arteriography is indicated.
3. Ligation of the inferior vena cava should precede embolectomy if the patient's condition will permit; if not, it should always be a part of the same operative procedure.
4. Cardiopulmonary bypass should always be employed, when available, for pulmonary embolectomy. The use of inflow tract occlusion is the second choice, but may be successful under ideal circumstances.

Addendum. Since this paper was accepted for publication on June 23, 1964, an additional eight cases of pulmonary embolectomy have been performed, with two survivors in this group, and will be reported at a subsequent date.

650 South Central Avenue.

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4. Sautter, R. D., et al.: Pulmonary embolectomy. Report of case with preoperative and postoperative angiograms. New Eng. J. Med. 269: 997–999 (Nov 7) 1963.
5. Cooley, D. A., and Beall, A. C., Jr.: Progress in cardiovascular surgery: surgical treatment of acute massive pulmonary embolism using temporary cardiopulmonary bypass, Dis. Chest 41: 102–104 (Jan) 1962.

GUIDE AVAILABLE

When is a pilot fit to fly? Some medical factors which must be considered by the occupational physician in deciding whether pilots of corporate aircraft can be expected to fly safely and efficiently are covered in a report just released by the Industrial Medical Association and the Aerospace Medical Association. Entitled "Medical Aspects of Business Aviation," the guide is an invaluable tool for any physician who has responsibility for the health of pilots of business aircraft. Single copies may be obtained by sending requests accompanied by 25 cents in postage stamps to the Industrial Medical Association, 55 East Washington St., Chicago, Ill. 60602.

UW Pharmaceutical Chemists Isolate Tumor-Inhibiting Compounds

In a major research program, pharmaceutical chemists at the University of Wisconsin, Madison, have isolated three active compounds in their search for drugs that inhibit the growth of cancer. The compounds were extracted from plants used for centuries in folk medicine, according to Prof. S. Morris Kupchan of the department of pharmaceutical chemistry, who heads the research.

From the several thousand plants from all over the world screened so far for antitumor activity, over 100 active plant extracts and several tumor inhibitors have been isolated. One of the active compounds, calotropin, was isolated from Asclepias curassavica, a plant used in the treatment of cancers, tumors, and warts for many years in Costa Rica, Mexico, and India. At the Cancer Chemotherapy National Service Center of the National Cancer Institute, which did the testing, the extract was found to inhibit the growth of tumors in tissue culture.

From American Indian hemp, Apocynum cannabinum, another tumor inhibitor was obtained. Systematic fractionation of the extract led to the isolation of two active principles, apocannoside and cymarin. The structures of these two and calotropin are very similar and all belong to a chemical group of compounds, the cardiac glycosides, which have digitalis-like activity.

An article on Prof. Kupchan's research in the Jan. 11 issue of *Chemical and Engineering News* points out that possibilities of improving known cancer drugs by chemical modification are nearly exhausted.

"Elucidating the structures of plant-derived tumor-inhibitors may yield novel chemical templates for new approaches to cancer chemotherapy," the article states.

Dear Doctor:

The following two communications were sent early in February to the Chiefs of Staff of Wisconsin hospitals. They were prepared by the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments. It is the Division's hope that procedures will be set up as suggested, because it feels these are matters of importance that require full cooperation and support.

IDENTIFICATION OF THE NEWBORN

Proper identification of the newborn is imperative, not only for the immediate post-delivery period, but also for a positive identity after the baby leaves the hospital. To avoid any possibility of confusion while in the hospital, the newborn should be banded *in the Delivery Room.* The banding should be of a type which cannot be removed and replaced. Double banding (arm and leg or 2 arms) is desirable for two reasons: First, although occasionally a band may slip off over the hand or foot, the loss of two bands at once is improbable; secondly, when the baby is discharged from the hospital, one band may be kept on the baby and the other band can be cut off and added to the permanent hospital chart. *It is highly desirable that when the baby is discharged from the hospital, the identification be checked with the parents.*

Although banding is one of the best methods for identifying the baby in the hospital nursery, this offers no permanent way of identifying the baby. If a newborn is lost, kidnapped, or separated from the parent in the first few months of life, there should be some way of making a positive identification of the child. For this reason *footprinting of the baby, along with fingerprinting of the mother, is recommended.* The quality of the prints is of great importance, and therefore, the personnel taking the prints should be carefully instructed and the prints should be periodically checked either by the company supplying the footprinting material or by the local law enforcement agency.

In summary, the following recommendations for the maternity hospital regarding newborn identification are:

1. Double banding of the baby.
2. Footprinting of the baby plus a fingerprint of the mother.
3. These procedures should be accomplished before the mother and her newborn leave the Delivery Room.

JOHN R. EVRARD, M.D., *Chairman*
Division on Maternal and Child Welfare
Commission on State Departments

"ROUTINE ORDERS" IN OBSTETRICS

It has been called to the attention of the Division on Maternal and Child Welfare that some physicians are still using "routine orders" *(applying to all patients)* and signing these for prepartum and postpartum orders. This is entirely unacceptable, both from the medical viewpoint and also with the Joint Commission for Accreditation. Recently, to facilitate writing the orders which physicians usually use before delivery and after delivery, some have devised rubber stamps with their own orders printed on the stamp. There have also been check-off lists designed so that the doctor may check off what he desires his patient to have. Both the stamp and the check-off list are acceptable procedures, *providing the doctor signs the list or the rubber stamp, and providing that he individualizes each case so that he excludes the orders on either list which do not apply to his patient, covered by the individual orders.*

JOHN R. EVRARD, M.D., *Chairman*
Division on Maternal and Child Welfare
Commission on State Departments

MAY 15 IS ABSTRACTS DEADLINE FOR AHA SCIENTIFIC SESSIONS

May 15, 1965 is the deadline for submitting abstracts of papers to be presented at the American Heart Association's 1965 Scientific Sessions, scheduled for October 15–17 in the Hotel Americana, Bel Harbour, Florida.

Papers should be based on original investigations in the cardiovascular field or related to such studies. Abstracts, briefly digesting results obtained and conclusions reached, should be limited to 250 words.

Forms for submitting abstracts of papers may be obtained from Richard E. Hurley, M.D., American Heart Association, 44 East 23rd Street, New York, N.Y. 10010. Applications for scientific exhibit space are also available from Doctor Hurley. These must also be returned no later than May 15, 1965.

Milwaukee's Radiologic Heritage

By J. E. HABBE, M.D., F.A.C.R.
Milwaukee, Wisconsin

■ MEDICAL RADIOLOGY began in Milwaukee a few weeks after the announcement by Dr. Wilhelm Konrad Roentgen on Dec. 28, 1895, regarding "a new kind of ray." The honor of being the first to successfully make a glass plate reproduction showing the shadows of the bones of the fingers surrounded by the soft tissues, belongs to Mr. Jacob A. Janssen,[1] a registered pharmacist, then 26 years of age; the time was February or March 1896; and the place was Milwaukee. The radiographic exposure time was given as approximately 45 minutes! In terms of today's radiographic standards, it may be fairly said that the part was certainly not overexposed!

Further efforts at medical radiographic procedures were made occasionally during the ensuing several years. It is said that young Janssen, continuously interesting himself in the development of x-ray equipment suitable for medical radiography, and learning gross human anatomy, equipped himself with portable x-ray equipment which could be mounted in a truck.[2] This was transported on call to the bedside at any of the several hospitals then existent in the Milwaukee area, notably St. Mary's Hospital, which opened in 1857, and Milwaukee Hospital in 1863.[3]

Fig. 1—Mr. Jacob A. Janssen, pioneer radiographer of Wisconsin. He made a 45-minute exposure of human fingers on a glass plate early in the spring of 1896, a few weeks after Raentgen's historic annauncement made Dec. 28, 1895.

Soon after the beginning of the twentieth century, x-ray units were being installed in hospitals and physicians' offices. Dr. William B. Sickles, a graduate of the Detroit College of Medicine in 1896, was probably the first to own and operate a diagnostic x-ray unit in his office in 1905.[4]

As was of course true throughout our country, and undoubtedly in other parts of the world, the first medical radiographers were by no means always physicians. Milwaukee's first was a registered pharmacist, not a physician. By self-training and close working relationships with physicians, especially the staff of Milwaukee Hospital, he became a respected member of the staff and continued as such until his death in 1937. A dinner given in his honor several years before his death by the staff of Milwaukee Hospital attested to the respect accorded his work by Milwaukee physicians.[3]

Others of the 13 charter members of the x-ray society of Milwaukee maintained interests divided between general practice and radiographic examinations, laboratory medicine, industrial medicine, dermatology, and radiotherapy.

The first physician to apply radium therapeutically, a life-long member of the American Roentgen Ray Society, and still practicing dermatology at the age of 88 years, is Dr. Otto H. Foerster, a graduate of the University of Pennsylvania in 1898. Doctor Foerster recalls being informed by his professor of medicine the likely tremendous importance of the "new ray" when it was first told him and his classmates in the year 1896.[5] The treatment was given in 1902.

Likewise, the first application of therapeutic x-radiation in Milwaukee is attributed to Dr. Samuel Friend, also a dermatologist, in 1903.[5]

About 1919 or 1920, a small group of physicians formed The Physicians' Radium Association of Wisconsin, Incorporated, and obtained approximately 300 milligrams of radium in the forms of capsules, a few needles and several placques.[6] These sources were available for use by the members and any other physicians who were deemed qualified to apply the element. Dr. Alfred W. Gray, an internist, served as president and Dr. Joseph P. McMahon as secretary-treasurer for many years. About 1935 the corporation was dissolved and all of the radium became the property of Dr. Carl Henry Davis, Milwaukee obstetrician and gynecologist.

Presented before the fortieth anniversary dinner meeting of The Milwaukee Roentgen Ray Society Nov. 25, 1963, at the University Club, Milwaukee.

Fig. 2—First known x-ray repraduction made in Wisconsin by apparatus assembled by Mr. Janssen, a 45-minute exposure made in early spring of 1896 in Milwaukee. (Reproduced with permission of Mrs. Hans Hefke and Dr. John Armbruster.)

Still later Columbia Hospital obtained ownership.

The first radiologic organization in Milwaukee, about which we know the details, since there are well kept secretaries' notes dating back to December 21, 1923,[7] was the organization now known as the Milwaukee Roentgen Ray Society. At the time of its organization and for a few years thereafter, the name was the Milwaukee County Radiological Society.

An intriguing note is on the first page of the original secretary's notes of the first meeting held Dec. 21, 1923, at Mount Sinai Hospital, upon an invitation by Dr. Harry B. Podlasky. It states, "After considerable exchange of opinion and discussing the advisability of organizing a *new* society, rather than reorganizing a society which had gone out of existence some 15 years ago (1908!), it was moved to organize a new one and to name it The Milwaukee County Radiologic Society." Could it have been that the earlier group was so dominated by photographers, engineers, "medical electrologists," and other nonphysicians that it was decided to start afresh and limit membership to physicians?

Further on the same page it is also reported, "All members present were to act as a committee to draft a constitution and bylaws *and investigate the status of the old society.*" Unhappily, all the author's efforts to unearth facts regarding the earlier organization have been futile, even though some of the consultants interviewed were practicing in Milwaukee at the beginning of the twentieth century. We may guess that it was probably a heterogenous group like that described by Dr. B. H. Orndoff[8] in his presentation on the early days of radiology at the fiftieth anniversary dinner meeting of the Chicago Roentgen Ray Society at Chicago in 1963. It is known that Mr. Janssen was not the only nonphysician who was available for making radiographic studies on request of attending physicians. This situation continued for some years until it became evident that the prime requisite for doing medical radiology was a complete medical education.

For this same reason, a proprietary Radium Hospital,[9] which came into existence in the year 1919, operated for only a few years. Undoubtedly there was ineffective control of the malignant cases, most of which we may assume were in advanced stages.

The initial meeting at Mount Sinai Hospital was called by Dr. Harry B. Podlasky, director of the X-Ray Department and teaching head of radiology at Marquette University School of Medicine. It was attended by Dr. Frank Mackoy, director of the Diagnostic X-Ray Service at Sacred Heart Sanitarium and also its gastroenterologist; Dr. George Stevens, an osteopathic physician who was then the roentgenologist at Columbia Hospital; Dr. Paul Eppersen, director of the X-Ray Department at St. Mary's, the oldest hospital in Milwaukee, who also had an office for private practice; and Dr. Clarence Geyer, who also practiced in the downtown area and directed the x-ray work at the Marquette University hospital, an institution of about 125 beds with an outpatient dispensary service at Ninth and Wells streets.

At the second meeting held at the Milwaukee Athletic Club on Jan. 4, 1924, in addition to the five named above, the following were also declared charter members: Drs. Otto and Harry Foerster, dermatologists engaged in radiation therapy of skin and superficial diseases; Dr. C. A. H. Fortier, director of the X-Ray Department at Deaconess Hospital and consultant to hospitals in Racine; Dr. Eugene Smith,[10] an industrial physician and surgeon who had served as radiologist in a base hospital in France during World War I;

Mr. J. S. Janssen, radiologist at Milwaukee Hospital; Dr. J. J. Seelman, director of a clinical laboratory, in the downtown area, which was equipped with diagnostic x-ray and usually had a trained radiologist in association; Dr. William Sickles,[4] a general practitioner who had perhaps the first diagnostic x-ray unit in the downtown area and who spent most of his medical career practicing in South Milwaukee after returning from military service in the first World War; and one other general practitioner, Dr. Alvin Kirmse, who practiced in Milwaukee only about two years and then returned to Arizona.

The secretary's notes of the meetings of the first several years of this Society showed that the adjournment time was often as late as 11:00 to 11:45 p.m.![7] Since these were years when there was no cocktail hour preceding the dinner and business meeting, these must indeed have been earnest young radiologists who were seeking to solve as rapidly as possible many of the problems confronting our then very young specialty!

Certainly it may be said of the group that it was not afraid to accept a challenge or a responsibility which might ordinarily have been considered beyond the achievement of its small membership. It acted as the host society for the 11th meeting of the Radiological Society of North America held in Milwaukee in 1926, just three years after the local society came into existence. Dr. Manley Sanborn of Appleton, Wisconsin, was the president of that national organization in 1926.

In preparation for the coming meeting, under the leadership of Dr. Clarence Geyer, no mean carpenter in his own right, the Milwaukee members gathered in the Geyers' basement and spent many evenings hammering together large, two-legged wood frame, film-viewing boxes[11] to be used by the scientific exhibitors. These view boxes continued to be serviceable at subsequent state and national meetings, including the American Medical Association meeting in 1933 and the Interstate Postgraduate Medical Assembly in 1935.* By that time reductions had replaced original films in most exhibits, and exhibit boxes have been modernized and made readily transportable.

Early in the life of the Milwaukee Roentgen Ray Society, it became common practice to invite physicians interested in roentgen diagnosis and roentgen therapy as guests at the monthly dinner meetings and to participate in the discussion of case presentations and to hear addresses of visiting radiologists from other parts of the country. Occasional joint sessions were held with the Chicago Roentgen Society,[7] and other nearby city organizations and radiologists from various cities in Wisconsin were frequently in attendance.

Another accomplishment of the local Society was gaining approval of the establishment of a Section on Radiology in the Wisconsin State Medical Society in the year 1924, the same year that the Section of Radiology of the American Medical Association came into existence.

During the years of the second World War, the Society's ranks were depleted by members entering the military service; and the monthly meetings were reduced to three or four annually. Attendance was small but the structure was maintained and the organization kept active. Those remaining at home served as radiologic consultants on Selective Service Boards.

Resident training spread to a number of the larger private hospitals and received approval of the Board of Radiology, broadening the opportunities for training in radiology in addition to those previously established programs at the Milwaukee County General Hospital and at the Veterans Administration Hospital at Wood.

To Mr. Janssen also belongs the distinction of making a radiographic study of the chest of President Theodore Roosevelt, when

Fig. 3—Sixth Street and West Wisconsin Avenue (then Grand Avenue) looking east toward Milwaukee River, as downtown Milwaukee looked when Milwaukee Roentgen Ray Society was founded Dec. 21, 1923. (Reproduced with permission of Milwaukee County Historical Society.)

* Both held in Milwaukee.

an attempt on his life was made in Milwaukee on Oct. 12, 1912.* The glass plates were taken at Milwaukee Emergency Hospital located at that time just a few blocks from the place of the attempted assassination. Later Mr. Roosevelt was transported to Chicago for surgical consultation by Dr. John B. Murphy who decided against attempting immediate removal of the bullet.

Fig. 4—Dr. Harry B. Padlasky, founder of the Milwaukee Roentgen Ray Society. Doctor Padlosky was first chairman of the Division of Roentgenology of Marquette University School of Medicine. Russian born, a man of fine education and personal charm, he came to the United States as a boy and practiced general medicine in Milwaukee until World War I. He returned in 1919 as one of the first physicians in Milwaukee to specialize in roentgenology.[16]

Beginning about 1940 solo practice in hospitals, clinics, and private offices gave way to the formation of radiologic partnerships. In more recent years group practices have been formed with a natural division of interests and responsibilities into the diagnostic and therapeutic phases of radiology as we know it today. Now many of our hospitals have radiation therapists and directors of isotope laboratories, whose work is largely if not entirely confined to that phase of our specialty.

In 1937, a collection of about 20 old Crookes, Eureka, and other gas tubes, owned by Mr. Jacob Janssen, was a part of the scientific exhibits of the Wisconsin State Medical Society's annual meeting. It attracted much attention. The collection was housed in cases for a time at the Marquette University School of Medicine following the death of Mr. Janssen in 1937; it is now in the Milwaukee County Historical Museum at the County Courthouse.[12]

In 1958, during the presidency of Dr. Robert Byrne, a recognition dinner was given honoring Drs. Hans Hefke (recently deceased), S. A. Morton (now professor of Radiology, American University Hospital and Medical School, Beirut, Lebanon), and J. E. Habbe, for their many years of service to radiology and medicine in Milwaukee. In their honor, a biennial lectureship was established at which an outstanding radiologist is invited to lecture.

See page 32 of this issue showing reproduction of historical document now part of the CES Foundation collection.

In November 1963, the program consisted of a historical review of early radiology in Milwaukee, in recognition of the fortieth anniversary of the founding of the Society. Doctor Habbe showed slides of the founder and charter members, of the two medical school buildings, Wisconsin College of Physicians and Surgeons and Milwaukee College of Medicine, which in 1911–1912 became respectively the medical school building and the University Hospital and Dispensary of the Marquette University School of Medicine.[13]

Radiologists' Role in Medical Practice. Some of the problems affecting the pioneers in our field such as the lay or otherwise untrained practitioner, the use of the hazardous nitrate-base films, the replacement of the cranky gas tubes by the high vacuum, hot-cathode tubes, replacement of dangerous nonshockproof equipment by shockproof, and the recognition that radiology is an integral and important part of the practice of medicine, have been solved and the place of the radiologist in the field of medical practice assured. Other problems await satisfactory solution.

Gradually efforts to maintain the position of the radiologist in his hospital practice, free to carry on his work unhampered have been successful. Likewise, the opportunities for maintaining a private practice in radiology have been improved somewhat by some insurance plans with the broadening of in-office benefits, both for diagnostic and therapeutic radiology. There are fewer radiologists doing private office practice today in Milwaukee than when the author arrived in Milwaukee in 1927 to reopen the office of Dr. C. W. Geyer, who had died a year earlier. If insurance coverages will permit free choice by patient and referring physician the use of radiologists' services in private office practice equal to those available in hospital outpatient departments, there is no reason why

Fig. 5—Dr. Frank W. Mackay, first president of the Milwaukee Roentgen Ray Society, 1923–1924. Doctor Mackay served Sacred Heart Sanitarium both as its roentgenologist and gastroenterologist and succeeded Doctor Padlasky as teaching head in roentgenology after Doctor Padlasky's death in 1935.[14]

private radiologic practice in Milwaukee should disappear completely. There are still physicians in Milwaukee who believe that the individual initiative and service facilities of the radiologist doing private practice deserve the support of the medical profession at large.

A number of the larger industries in the Milwaukee area with large employee populations have established various forms of EMBA benefits and medical services. These offer opportunities for the radiologist to enjoy the same type of patient relationships as in private practice, commonly no longer available to the diagnostic radiologist with his tremendously heavy hospital load. In private practice one is usually able to individualize the diagnostic studies to be carried out to best serve the patients' needs.

In May 1964, the Society's membership numbered approxmately 45, including several physicians practicing in nearby communities. The residents in training in various Milwaukee hospitals are regularly our guests at the monthly dinner meetings and scientific programs. Our organization has a respected position, with a voice to be heard in organized medical circles in Milwaukee, and contributes its share to the organizational activities of the Wisconsin State Radiologic Society, Inc. as well as the Milwaukee County and Wisconsin State medical societies.

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231 W. Michigan St.

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FILM ON SALMONELLOSIS

Available to physicians and other groups is a 16 mm color and sound film on "The Epidemiology of Salmonellosis in Man and Animals," produced by the Public Health Service Audiovisual Facility for the Communicable Disease Center, Atlanta, Ga.

The 15-minute film tells the story of salmonellosis, its nature in humans and animals, symptoms, etiologic agent, and its economic impact on farmers. It may be obtained on free short-term loan from: Public Health Service Audiovisual Facility, Atlanta, Ga. 30333, Attn: Distribution Unit, or by purchase from: DuArt Film Laboratories, Inc., 245 W. 55th St., New York, N.Y. 10019.

Related films are "An Outbreak of Salmonella Infection"—M-148a, and "Methods for the Isolation of Salmonella from Human Food and Animal Foods" —M-553.

PAMPHLET ON MEDICAL CARE

Reliable criteria for judging a doctor's competence and a hospital's care are to be found in *How to Get Good Medical Care*, by Irvin Block, a Public Affairs Pamphlet issued in January. It is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

Success of UW Computer Test Points to Long-Distance Diagnosis

Men of medicine may be able to diagnose patients by "long-distance," using a type of computer system tested successfully at the University of Wisconsin in Madison.

Completion of the first two-way long distance feedback experiment dealing with medical research and diagnosis on respiration has been announced by Prof. Karl U. Smith, director of the University's Behavioral Cybernetics Laboratory, and Dr. John Henry, research service, Hines, Ill., Memorial Hospital.

In their experiments, two-way data-phone links were established between a closed-loop computer system on the University campus and the respiratory hospital facility outside Chicago. Purpose of the testing was to check new cybernetic methods in remote control of the feedback effects of diseased organic functions.

"We observed a marked difference between normal persons and those troubled with respiratory ailments," Professor Smith noted.

"The main outcome of the studies has been to show how the doctor, working at some remote point in the hospital or in his office, can receive signals pertaining to the patient's body functions, and then have a means to analyze the situation," Professor Smith explained.

Spondylolysis and Spondylolisthesis Are Not Congenital

By ABRAHAM MELAMED, M.D.
Milwaukee, Wisconsin

■ ALTHOUGH SPONDYLOLYSIS with or without displacement has never been demonstrated at birth, many observers persist in advancing the congenital theory of etiology of these conditions. Neither separate ossification nor defect in the pars interarticularis has been found in over 700 fetuses which were sectioned from the fourth month of gestation to shortly after birth.[1] According to Sullivan and Bickel[2] the acceptance of "congenital spondylolysis" as an entity is a perpetuation of early erroneous observations.

The etiology of spondylolysis is the subject of an excellent paper by Wiltse[1] published in 1962. It is my purpose to confirm some of his observations. The theories of etiology listed by Wiltse are as follows: separate ossification centers, birth fracture, fracture during postnatal life, stress fractures, increased lumbar lordosis, impingement of the articular processes on the pars interarticularis, weakness of supporting structures, pathologic changes in the pars interarticularis, high familial incidence, racial tendencies and predisposition, and dysplasia of the pars interarticularis.

To reiterate, separate ossification centers or defects in the pars interarticularis have never been found at birth or in a stillborn infant. However, there are at least two reports in the literature dealing with spondylolysis in infants. Friberg[3] described what is probably the youngest patient with spondylolysis on record. His patient with multiple interarticular defects and other deformities was 11 months old. She had never sat up or walked. Kleinberg's[4] patient with spondylolisthesis was 17 months old. In both reports cited above, the opinions of the authors notwithstanding, there is no proof that the interarticular defects were present at birth. Spondylolysis usually develops under the age of 10 years. Baker and McHolick[5] conducted a mass x-ray survey of 400 first grade school children, 6 to 7 years of age. Eighteen cases of spondylolysis were found—an incidence of 4.5 per cent. This is comparable or equal to the findings in adult surveys.

Rowe and Roche[6] were unable to produce fracture of the pars interarticularis in stillborn infants. However, well documented fractures during postnatal life and as the result of severe trauma are described in the literature.[1, 7-11] Such fractures heal as a rule. Instances of such fractures seem to be rare but we were fortunate to have had the opportunity of observing such a patient.[11] He was 15 years of age at the time he sustained bilateral fractures of the partes interarticularis of the fourth lumbar vertebra as the result of football injuries. Five years later complete healing of these fractures was demonstrable. The patient had worn a brace for 6 months.

Many authors[1, 12-18] consider stress an important factor in the etiology or pathogenesis of spondylolysis. Lumbar lordosis and the erect stance in man are undoubtedly important etiologic factors. As a result, the interarticular portions of the lower lumbar vertebrae are subjected to considerable downward and forward stresses. On the other hand, exaggerated lumbar lordosis, per se, seems to be of no significance. Lumbar lordosis and lumbosacral angulation are not increased at the time spondylolysis develops or soon thereafter (Fig 1).

Defects do not occur in the ape or other primates but have been found in prehistoric man.[1] There is no record of defective pars interarticularis in any animal below man.

Nathan[19] proposed that the clefts in the pars interarticularis of the fifth lumbar vertebra in "typical" spondylolisthesis are the result of a pincer effect on the isthmus by the upward projecting superior articular processes of the vertebra below and the downward projecting inferior articular processes of the vertebra above. In 1893 Lane[20]

From the Department of Radiology, Evangelical Deaconess Hospital.
Presented at the 123rd Annual Meeting of the State Medical Society of Wisconsin, May 13, 1964, Milwaukee.

Fig. 1—Illustrations of patients 10 years of age and younger with spondylolysis in fifth lumbar vertebra, with or without listhesis. Arrows indicate defects in isthmi.

advanced the same theory. I agree with Wiltse[1] that such conditions do not obtain in childhood when most cases of spondylolysis develop (Fig 1). In the examples shown there is no impingement of the isthmi. Nathan analyzed skeletons and roentgenograms of old people. Degeneration and/or narrowing of the intervening disk, exaggerated lumbar lordosis, increased lumbosacral angulation, approximation of the articular processes, and the like represent late changes.

Newman[21] suggested that spondylolysis is secondary to weakness of the supporting structures of the spine. There is no evidence to support this theory. Patients with polio and other neuromuscular involvement show no greater incidence of spondylolysis.

The familial and racial incidences of spondylolysis are well established. Wiltse[1] reported an incidence of 40 per cent in members of families with spondylolysis. It is believed that a single recessive gene with incomplete penetrance is the cause, but some affected individuals may be carriers (heterozygous) for the gene. Eskimos show an incidence as high as 50 per cent[24] in northern localities, suggesting a hereditary factor.

Microscopic examination of many specimens with spondylolysis and spondylolisthesis has not revealed aseptic necrosis, blood lakes, cysts, callus or fracture healing. Wiltse[1] removed the posterior elements of the vertebrae in 15 cases of spondylolysis and summarizes his findings, as follows: "In most

cases, dense, relatively acellular, fibrous tissue was attached intimately to the bone, seeming to penetrate quite deeply in some areas. There was usually an abrupt transition from fibrous tissue to bone." Wiltse stated further, on the basis of tetracycline uptake studies in one case, ". . . the defective pars interarticularis is not a portion of bone of low vitality as has been suspected, but is functioning as other bone and contributing to the body's pool of bone metabolites."

Wiltse's concept of the cause of spondylolysis seems logical and the most reasonable to date. He believes that disruption of the pars interarticularis is due to (1) strain on the pars interarticularis in the lower lumbar spine as the result of man's erect posture and lumbar lordosis, and (2) a hereditary dysplasia. Unless dysplasia exists, spondylolysis will not and cannot develop. The stress or strain factor has been discussed above. True fractures of the pars interarticularis due to severe trauma are the exception, but healing always or almost always takes place in these cases.

Wiltse considers the dysplasia a hereditary weakness, characterized by a lack of the normal ability of the bone to repair itself. Bone resorption and bone formation are normally going on continuously. If resorption exceeds formation the area involved will be unable to tolerate the normal stresses and strains, eventually yielding to such forces and resulting in the characteristic defect of spondylolysis.

A case we reported[22] in 1957 serves as an excellent example. The patient was originally observed for the condition of infectious chondritis at the L 2–3 junction, first detected radiographically at the age of 18 months. The patient developed spondylolisthesis in the fifth lumbar vertebra during the period of observation between the ages of 5 years 4 months and 8 years 6 months without any intervening history of severe trauma.

Cozen[23] reports similar observations and findings in another child who developed spondylolysis between the ages of 5 and 7 years. Such examples are consistent with the belief that spondylolysis is not seen at birth but develops during childhood, as a rule before the age of 10 years.[5] The incidence evidently varies in different races, however, increasing in adulthood in Eskimos to the age of 40. In some northern localities the incidence in Eskimos reaches as high as 50 per cent of the skeletons examined.[24]

It is well to point out again that the spine of the afflicted patient is surprisingly normal in appearance in all other respects until the secondary changes set in. Wiltse[1] claims that spina bifida occulta and scoliosis are more common in patients with spondylolysis. I am not certain about spina bifida, but in our experience with patients under the age of 10 years scoliosis is infrequent or inconsequential.

Summary. Dysplasia based on a hereditary defect in the cartilage model of the arch of the affected vertebra seems to be the main underlying etiologic factor in spondylolysis and in spondylolisthesis due to defects in the pars interarticularis. The strain or stress attendant to the erect human posture and lumbar lordosis is an added factor which fosters the development of dissolution or disruption in the interarticular portion of a "susceptible" vertebra. One factor or force may be greater than the other, but the end result is the same. In infants stress may be minimal but the dysplasia factor is sufficiently prominent to bring about lysis of the pars interarticularis. Such circumstances would explain upper lumbar and/or unilateral examples of spondylolysis.

An attempt has been made to review very briefly the essential etiologic aspects of spondylolysis and of spondylolisthesis due to defects in the pars interarticularis and to dispel the widely accepted thesis that these conditions are congenital in origin. Evidence is at hand to indicate an acquired etiology, hereditary in many instances.

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FOR YOUR INFORMATION—from the Wisconsin State Laboratory of Hygiene

Reprinted from LABORATORY NEWSLETTER, December 1964

IMMUNOLOGY: THE ANTISTREPTOLYSIN TEST

The microtiter technique is now being used for antistreptolysin O titers, using dilutions from 1:16 to 1:8192. In accord with recommended reporting methods the reciprocal of the titer will be given; this represents what are called Todd units. For example, a 1:256 titer will be reported as 256 Todd units. Values through 128 Todd units can be considered in the normal range whereas values greater than 512 Todd units usually indicate a recent streptococcal infection. A change in titer in serial specimens gives more information than a single specimen.

APPROVAL, EVALUATION, AND QUALITY CONTROL PROGRAMS

Milk and Water. Since 1951 when the state legislature provided for the program, the State Board of Health has maintained an approval program to insure the reliability of laboratory examinations of milk and water for the protection of the public health. There are now 126 laboratories approved for testing milk and/or drinking water for purity.

Syphilis Serology. Approval to perform premarital blood tests started as a voluntary program in 1958. In 1962 new regulations approved by the Board of Health required that laboratories be evaluated before being certified to perform premarital blood tests. At the present time, 68 laboratories are certified and 10 laboratories are being evaluated for certification.

Clinical Chemistry. A voluntary quality control program in clinical chemistry was started in November, 1963. Now, about 80 laboratories throughout the State are participating. Specimens are mailed out each month to these laboratories and to the Communicable Disease Center, Atlanta, Georgia, Bio Science and Biochemical Procedures Laboratories, both in California. These three laboratories act as reference laboratories and perform several different tests on each specimen.

Further information on these programs may be obtained by writing to A. S. Evans, M.D., Director, State Laboratory of Hygiene, University of Wisconsin, Madison, Wisconsin 53706.

SYPHILIS SEROLOGY—CHANGES IN THE PROCEDURE FOR DIAGNOSTIC PROBLEM CASES

After several years of comparative testing substantiated by published reports of other workers, the K.R.P. (Kolmer Complement Fixation with Reiter Protein) also known as the R.P.C.F. will be replaced by the F.T.A.–200 (Fluorescent Treponemal Antibody) test.

Various papers have pointed out that the K.R.P. (RPCF) is of limited value as a confirmatory test or as a test to eliminate the biologic false reactor because of poor reproducibility and a lack of good sensitivity.

The F.T.A.–200 has a high specificity and a relatively high sensitivity and the agreement with the T.P.I. is of the order of 90–95%.

AS OF JANUARY 1, 1965, ALL REQUESTS FOR THE K.R.P. (RPCFE) OR ADDITIONAL CONFIRMATORY TESTS WILL BE FILLED BY PERFORMING THE F.T.A.–200.

In using the fluorescent treponemal test, physicians should recognize that this test may become positive later than the VDRL test. Problem patients suspected of early syphilis with a positive VDRL and a negative treponemal fluorescent test should therefore be retested at a later point before considering this as a biologic false positive and ruling out syphilis. A new mimeographed outline entitled "Suggested Procedure for Diagnostic Problem Cases" is available on request.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: B. J. BAUMAN, M.D.
Madison, Wisconsin

Case Presentation.* *Dr. B. J. Bauman:* A 46-year-old white man employed as an auditor and office worker was admitted to the hospital in May 1964 with the chief complaints of night sweats, unexplained fever, fatigue, and approximately a 30-to-40-pound weight loss, the latter occurring gradually over a four-month period. His symptoms had begun in January 1964. In March 1964 he developed severe pain and swelling in the rectal area with subsequent spontaneous drainage of a perirectal abscess and development of a rectal fistula.

In April 1964, in another hospital, he underwent rectal surgery with wide excision of the anal fistula. The excised margins of the fistula tract were reported to show only acutely and chronically inflamed tissue with foreign-body type granulomatous inflammatory reaction. The site of rectal surgery healed slowly and was not completely healed at the time of admission to this hospital in May 1964. Following rectal surgery the patient continued to have unexplained fever, fatigue, progressive weight loss, and night sweats. Broad spectrum antibiotic therapy failed to produce any obvious improvement.

Past medical history revealed that for several years prior to January 1964 the patient had enjoyed good health but was taking colchicine (Colchin) and probenecid (Benemid) to remain symptom-free of gout. During World War II, he had served in the military service in the South Pacific area for 3½ years, during which time he had dengue fever, malaria, amoebic dysentery with secondary anemia, and combat fatigue.

Family history revealed that his mother had died of a heart attack and aplastic anemia. His father was living but was an invalid as a result of a cerebral vascular accident. He had three brothers living and well.

Social history revealed that he smoked approximately one pack of cigarettes a day from 1940 to 1960. He frequently drank three or four bottles of beer a day.

Pertinent findings under systemic review revealed that since his recent weight loss, he had noticed increased shortness of breath. He denied symptoms referable to the eyes, ears, nose, throat, gastrointestinal (GI) tract, genitourinary (GU) tract, or neuromuscular system. He was noted to have had microscopic hematuria for several months but denied ever having gross hematuria or dysuria. Prior to being hospitalized in May his hemoglobin level was 10.4 gm/100 ml.

Physical examination at the time of admission to the hospital in May 1964 revealed the patient to be a well developed but thin white man who appeared chronically ill. Vital signs included a temperature of 100.4 F, pulse rate 100, respirations 18, and blood pressure 110/74 mm Hg. His skin presented a generalized ashen color. Physical examination was unremarkable except for the presence of a poorly healing previous anal fistulectomy.

Peripheral blood studies at the time of the patient's hospital admission revealed his white blood cell count to be 14,800 with a differential of 8 stab forms, 76 segmented cells, 8 lymphocytes, 4 monocytes, and 4 eosinophils. Subsequent blood smears taken throughout the hospital course revealed a persistent leukocytosis with a shift to the left and varying degrees of toxic granulation. His hemoglobin level on admission was 10.2 gm/100 ml. Hematocrit reading was 32% and the mean corpuscular hemoglobin count was 32%. Corrected sedimentation rate was 30 mm per hour. Repeat urinalyses revealed a persistent albuminuria (2+ to 4+) and persistent microscopic hematuria. A venereal disease research laboratories test for syphilis was nonreactive. Blood urea nitrogen (BUN) on May 23, 1964, was 22.5; on July 10, it was 204, and on July 15, 192 mg/100 ml.

* From St. Mary's Hospital.

Peripheral blood lupus erythematosus tests and blood and stool cultures were negative. Fasting blood sugar was 125 mg/100 ml; cephalin flocculation test, 0; thymol turbidity test, 2 units; total serum bilirubin 0.5, and indirect serum bilirubin 0.5 mg/100 ml; serum alkaline phosphatase May 25, 1964, was 74.4 King–Armstrong units; alkaline phosphatase June 1, 1964, was 40.0 King–Armstrong units; uric acid 4.8 mg/100 ml; serum creatinine July 11, 1964, was 10.2 mg/100 ml; serum phosphorus 12.3 mg/100 ml; serum calcium 3.7 mg/100 ml; total serum protein, 5.6 gm/100 ml with 2.45 albumin and 3.15 globulin; urine cultures were negative; serum iron before blood transfusions were started was 15 μg/100 ml. Initial peripheral blood smears before blood transfusions revealed the red cells to appear normochromic and normocytic. Blood platelets appeared normal. Blood serum protein on June 2, 1964, was 11 mg/100 ml.

Roentgenologic Findings. *Dr. Richard Lindgren:* The patient's chest film on admission showed a heart of normal size and a 2.5-cm density lying peripherally in the right lung at the level of the anterior fifth interspace. In the lateral view it was shown to be in the right middle lobe. The density had very irregular margins, and in the lateral view there was suggestion of at least one small calcification in the mass. The borders were rather spiculated, and it almost seemed that there might be vessels projecting into it. Planograms were taken the following day. These showed no evidence of a calcification in the mass. The vessels projected behind it, and there was no evidence to believe that it was a vascular lesion such as an arteriovenous malformation. The consensus favored a diagnosis of primary pulmonary neoplasm until proven otherwise.

A follow-up chest film taken 17 days later showed no significant change in the appearance of the mass. A film one month after the admission also showed no change.

An incidental finding was a 1-cm calcified axillary node on the left. This apparently had no relationship to the current disease.

Films showed the paranasal sinuses to be normal. The gallbladder, upper GI series, and small intestinal series were also normal. There was some diverticulosis of the ascending colon which was demonstrated with the barium enema. An intravenous pyelogram revealed poor concentration of dye in both kidneys which could possibly be due to impairment of renal function. Retrograde pyelograms were normal. Postoperative chest films showed no significant findings.

Clinical Discussion. *Doctor Bauman:* On June 11, 1964, the patient underwent an abdominal exploratory laparotomy which was negative. Liver biopsy obtained during the laparotomy was nondiagnostic. July 3, 1964, the patient underwent a thoracotomy on the right side with resection of the middle lobe of the right lung. Pathologic examination of the excised lobe revealed necrotic granulomatous lesions, cultures of which revealed no fungi or acid-fast bacteria. Throughout his approximately eight-week course in the hospital the patient received at least 13 units of whole blood by transfusion.

His hemoglobin level ranged between 7.6 and 12.6 gm/100 ml. The last hemoglobin determination before discharge was 11.1. He remained normotensive throughout his entire hospital course. During his hospital course the patient became uremic with the BUN rising from 22.5 to 204 mg/100 ml. When discharged from the hospital on July 16, 1964, he was placed on adrenal cortical steroid therapy, specifically methylprednisolone, 15 to 20 mg, daily. The patient continued on this therapy until his death July 26, 1964, 10 days after discharge from the hospital.

Dr. Joseph C. Kiser: When extensive clinical examination of this patient, including cystoscopy, intravenous and retrograde pyelogram studies, cholecystographic studies, proctoscopy, and upper and lower GI roentgenologic studies, failed to reveal any evidence of a primary carcinoma in the urinary or intestinal tract, carcinoma of the pancreas was considered on the basis of exclusion of other primary sites. For this reason an abdominal exploratory laparotomy was performed.

At the time of the exploratory laparotomy, the colon and small intestine were normal as were the liver, pancreas, spleen, and stomach. The major vessels within the abdomen were normal and the adrenals were normal to palpation. Subsequent to the exploratory laparotomy, the patient received multiple transfusions to maintain his hemoglobin level at 10 gm, and on one occasion he developed diffuse petechiae over his lower extremities. At that time a clot retraction

and platelet count were normal as were the Rumpel–Leede test and the red blood cell fragility test.

All of his x-ray films were reviewed again and it was felt that the visible pathology in the right lung should be attacked. On July 3, 1964, a thoracotomy was performed on the right side. There was a 3-to-4-cm, yellowish-brown, peripheral lesion in the midportion of the right middle lobe which extended into the depth of that lobe. There were no palpable or visible hilar or mediastinal nodes that appeared to be involved in either an inflammatory or a malignant process. A right middle lobectomy was performed, and the frozen section diagnosis was a granulomatous lesion with active necrosis and nonspecific characteristics. The patient tolerated the thoracotomy well. His chest tube was removed on approximately the fourth postoperative day. The remainder of his course is best summarized by the internist and pathologist.

Dr. William Rock: I wish to reemphasize some of the salient points in the case presentation and discuss a few clinical features and data not previously mentioned.

When the patient first presented himself to the proctologist in April 1964 with a spontaneously draining rectal abscess, his only complaints were pain and swelling in the rectal area associated with chills, fever, and an approximate 10-pound weight loss. A chest x-ray film was not obtained when he was hospitalized in April for rectal surgery, and he had no symptoms referable to the respiratory tract. Laboratory studies at that time revealed no remarkable abnormalities. His hemoglobin level was 12 gm/100 ml and peripheral blood leukocyte count was within normal limits, with a normal differential. However, six weeks later when the patient continued to have a temperature which ranged up to 103 F plus an additional 20-pound weight loss, it was obvious that further investigation was warranted.

Physical examination revealed only a persistent draining area at the site of rectal surgery. A course of tetracycline antibiotic therapy produced no improvement in the draining rectal lesion or febrile episodes. Serum febrile agglutinins were negative. Shortly thereafter the patient began to appear cachectic; and repeat laboratory studies revealed a mild anemia, mild leukocytosis, and microhematuria. Chest x-ray films showed a lesion in the right middle lobe thought most likely to represent a malignancy. The clinical diagnosis favored at that time was probable hypernephroma with lung metastases. However, an intravenous pyelogram, cystoscopy, and retrograde pyelogram were negative which seemed to rule out neoplasm in the GU tract. Acute glomerulonephritis was felt to be ruled out by the absence of hypertension and edema and red blood cell casts in the urine. The elevated serum alkaline phosphatase of 75 King–Armstrong units was puzzling, since no other liver function tests were abnormal. An elevated blood serum protein of 11 mg/100 ml in a patient with a temperature of 103 to 104 F is certainly not unusual. A percutaneous liver needle biopsy proved negative.

Following this the decision was made to perform an abdominal exploratory laparotomy since the clinical picture seemed most in keeping with an abdominal neoplasm such as pancreatic or intestinal neoplasm with pulmonary metastases. Prior to the laparotomy the patient had a marked febrile reaction following transfusion of two units of whole blood. Although the patient had been febrile, this was viewed with some suspicion; however, retyping and recrossmatching revealed no blood group incompatibilities. The direct Coombs test was negative and serum bilirubin remained within normal limits. The patient's skin tests for purified protein derivative intermediate, histoplasmosis 1:100, blastomycosis 1:100, and coccidioidomycosis 1:100 were all negative. Papanicolaou smears of the sputum were normal.

The patient was repeatedly transfused because of the marked, persistent anemia, the exact etiology and pathogenesis of which remained unexplained. A bone marrow aspirate was obtained and interpreted to show mild granulocytic hyperplasia with no clue as to the etiology of the patient's anemia. A low serum iron of 15 μg/100 ml suggested an iron-deficiency or blood-loss anemia. The day following the febrile reaction to the two blood transfusions the patient suddenly developed a diffuse severe purpura over the entire body, involving chiefly the extremities. Repeat laboratory studies including capillary fragility tests, bleeding and clotting times, platelet count, and serum bilirubin were within normal limits.

By this time it was felt that the patient possibly had an allergic-type blood transfusion reaction. The purpura spontaneously cleared within a few days. Later, following thoracotomy, the patient developed a diffuse erythematous papular, pruritic skin rash which cleared when postoperative barbiturate sedation was discontinued.

When the pulmonary lesion was found to be a necrotizing granuloma with associated necrotizing vasculitis, it was considered that possibly the hematuria, the purpura, the lung lesions, and possibly the rectal abscess could be related to the same disease process, specifically Wegener's granulomatosis; however, there were no facial lesions, paranasal sinus films were negative, and the upper respiratory tract and nose were clear of disease. The patient deteriorated rapidly following thoracotomy and began to have episodes of confusion and delirium. He developed a flapping tremor but repeat liver function tests were within normal limits. The blood urea nitrogen then rapidly became markedly elevated; and it became evident that the patient was uremic, which tended to further substantiate the impression of Wegener's granulomatosis.

In spite of the patient's deteriorating clinical condition, he was discharged for morale purposes and placed empirically on prednisolone therapy, although the use of corticosteroids in Wegener's granulomatosis is usually of little benefit. While on steroid therapy he subsequently developed marked peripheral edema. Two days before death he developed pleural effusion with pulmonary edema and was felt to be in terminal heart failure. He suddenly collapsed in a state of shock at home and died shortly thereafter in the hospital emergency room 10 days after discharge from the hospital.

In retrospect I do not think that we would have significantly changed our clinical course of this patient with this peculiar and unusual disease. In the absence of any objective findings of an infectious disease process, our efforts were directed toward finding a primary tumor source. It was not until the patient was deteriorating with rapidly progressing uremia that we were finally able to group the findings into a specific disease syndrome.

Pathologic Discussion. *Doctor Bauman:* At autopsy the body for examination was that of a cachectic white man weighing approximately 120 pounds. The skin was pale and anicteric with rather poor turgor. No specific skin lesions were evident. The ankles showed a pitting edema (1+ to 2+). Upon entering the chest, massive bilateral pleural effusions were encountered, there being approximately 1,500 ml of serosanguineous fluid in the left pleural space and approximately 1,200 ml of similar fluid in the right pleural space. The thoracotomy wound in the chest on the right side was well healed. The pericardial space was almost completely obliterated by fibrinous adhesions between the visceral and parietal pericardium. A few milliliters of serosanguineous fluid were pocketed between the fibrinous adhesions over the posterior aspect of the heart, which was somewhat heavier than normal, weighing 430 gm. No cardiac valvular lesions were found. The coronary arteries showed only a mild degree of atherosclerosis. Histologic study of the heart revealed only diffuse fibrinous pericarditis.

The right and left lungs weighed 295 and 330 gm respectively. The right middle lobe was surgically absent, and the margin of excision at the hilus appeared to be healing satisfactorily. The lower lobes of both lungs were subcrepitant, firmer in consistency than normal, and sectioned surfaces presented a diffuse dark-red discoloration suggestive of diffuse hemorrhage. The upper lobes appeared congested. The tracheobronchial tree contained moderate amounts of blood-tinged, mucoid material. Careful search failed to reveal any ulcerative or other focal lesions in the larynx, trachea, or bronchi. No focal lesions were identified in either lung as were found in the previously resected right middle lobe. Thorough microscopic study of numerous sections from all lobes of both lungs failed to reveal any necrotizing granulomatous lesions or vascular lesions as were identified in the right middle lobe (Figs 1 and 2), which was resected 23 days prior to the patient's death.

The histopathologic features demonstrated throughout both lungs at autopsy were diffuse vascular congestion, hemorrhage, edema, thickening of the alveolar walls, focal fibrinoid alveolitis, the presence of small intra-alveolar clusters of fibrin exudate undergoing fibrous organization and clusters of hemosiderin-laden macrophages in the interstitial tissues and alveolar spaces. There was very little leukocytic inflam-

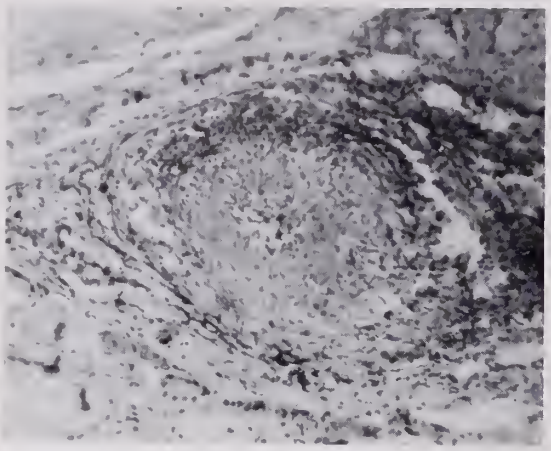

Fig. 1—Necrotizing arteritis, bronchial wall.

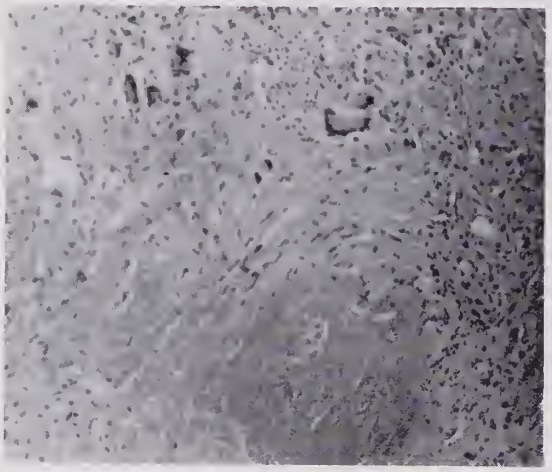

Fig. 2—Granulomatous lesion of lung with caseation.

Fig. 3—Acute fibrinoid necrosis, arterioles of small intestinal wall.

matory infiltrate throughout the lung parenchyma. These features were interpreted to represent uremic pneumonitis. Review of tissue slides from the previously resected right middle lobe showed necrotizing granulomatous lesions characterized by central areas of necrosis surrounded in some areas by a well defined band of fibrinoid necrosis in turn surrounded by a wide, irregular zone of proliferating dense connective tissue diffusely infiltrated with lymphocytes, plasma cells, eosinophils, histiocytes, and frequent Langhans' type giant cells.

In some of the adjacent larger bronchial walls foci of necrotizing granulomatous vasculitis were identified involving small arteries and arterioles. The involved vessels showed focal circumferential fibrinoid necrosis with surrounding inflammatory and epithelioid cell infiltration and the presence of occasional Langhans' type giant cells. The lumens of most involved vessels were obliterated by the necrotizing granulomatous process and some showed thrombotic occlusion. A few foci of necrotizing vasculitis were also identified in otherwise normal bronchial walls and lung parenchyma at a considerable distance from the parenchymal necrotizing granulomatous lesions.

Examination of the GI tract revealed the esophagus, stomach, duodenum, and proximal portions of the small intestine to be grossly unremarkable. In the distal portion of the ileum there was found a focal segment measuring about 3 cm in length and encircling the entire circumference of the intestinal wall in which the mucosal lining was diffusely congested, focally ulcerated, and contained scattered, small petechial hemorrhages. The ileum distal to this segmental lesion contained fresh blood. The colon contained about 1,200 to 1,500 ml of both fresh and old blood. An irregular patchy area measuring about 5 cm in greatest dimension was found in the cecum in which the mucosa was diffusely congested, focally ulcerated, and contained petechial hemorrhages, the features being similar to the segmental lesion found in the terminal ileum. These two lesions obviously represented the site of origin of the massive hemorrhage in the colon.

Microscopic study of the ulcerated lesions found in the terminal ileum and cecum re-

Fig. 4—External surface of swollen pale kidney with petechiae.

vealed a prominent acute necrotizing angiitis (Fig 3) in the intestinal wall subjacent to the hemorrhagic ulcerations in the mucosa. Many arterioles, small arteries, and veins showed acute circumferential fibrinoid necrosis frequently associated with a pronounced acute leukocytic exudative infiltrate in and about the vascular lesions. One section revealed ulceration of the wall of a medium-sized artery in the submucosa at the base of a mucosal ulcer. Necrotizing ulcerative colitis may occur in severe uremia; however, this did not appear to be the case here. The intestinal mucosa ulcerations noted were interpreted to represent small infarcts resulting secondary to segmental acute necrotizing angiitis in the vessels of the intestinal wall.

Both kidneys were symmetrically enlarged and heavier than normal, the right and left weighing 190 and 200 gm respectively. The renal capsules stripped easily, disclosing smooth pale grayish-white cortical surfaces diffusely dotted with minute, punctate petechial hemorrhages (Fig 4). Cut sections revealed the cortex of both kidneys to be studded throughout with innumerable minute petechial hemorrhages. The renal calyces, pelves, ureters, and urinary bladder were grossly unremarkable. Microscopic study of the kidneys revealed subacute diffuse necrotizing glomerulonephritis (Figs 5 and 6) with associated numerous foci of necrotizing angiitis involving primarily arterioles and small to medium-sized arteries.

Numerous sections from all areas of both kidneys showed uniform involvement of all glomeruli. Many glomeruli showed focal fibrinoid necrosis in the glomerular tufts with an associated inflammatory exudate. There was general glomerular ischemia associated with endothelial cell hyperplasia and thickening of the basement membranes. Most glomeruli showed epithelial or fibrous crescent formation with partial or complete obliteration of Bowman's space. There was total fibrous obliteration of some glomeruli. The segmental vascular lesions in the kidney were characterized by eosinophilic focal or circumferential fibrinoid degeneration of the vessel walls usually involving all coats with

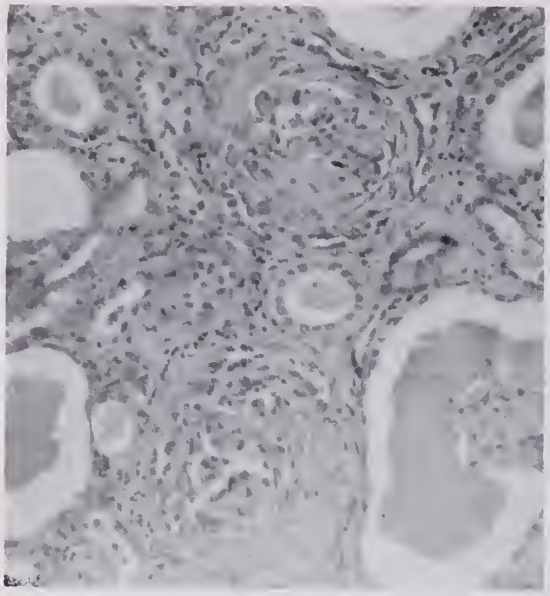

Fig. 5—Glomeruli of subacute diffuse necrotizing glomerulonephritis.

variable associated inflammatory reaction. The lumens of the involved vessels were markedly narrowed and many were occluded by thrombi.

The vascular lesions were both acute and chronic in nature with inflammatory involvement of all coats including the periadventitial tissue. Several small arteries in the adipose tissue about the ureters showed older chronic granulomatous vascular lesions with diffuse fibrous thickening of the vessel walls and a dense chronic inflammatory leukocytic infiltration throughout all layers. In addition to the pronounced glomerular and vascular lesions noted throughout both kidneys there was associated tubular atrophy and focal interstitial fibrosis with associated focal chronic interstitial inflammation. Many tubules throughout the cortex and medulla were dilated and contained both hyaline and granular casts.

Gross and microscopic studies of other tissues and organs including the brain revealed no additional pathologic findings; however, careful search for additional vascular lesions in other viscera revealed only two small arteries in the pancreatic interstitial tissues and two or three small arteries in the adipose tissue about the adrenal capsules which showed circumferential fibrinoid necrosis of the vessel walls with little associated inflammatory reaction.

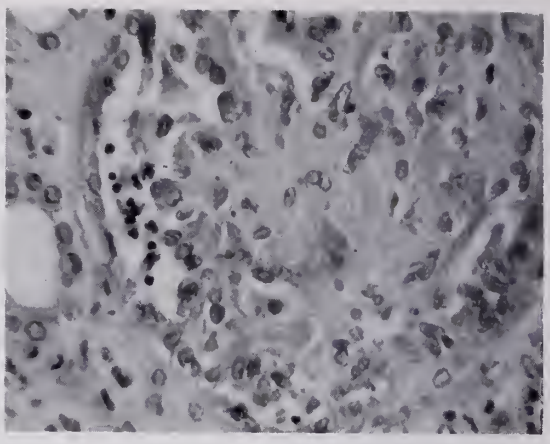

Fig. 6—Glomerulus showing focal glomerulitis.

The final anatomical diagnoses are summarized as follows:

(1) Wegener's granulomatosis manifested by
   a. necrotizing granulomatous lesions of the right lung,
   b. focal necrotizing vasculitis involving primarily the lungs, kidneys, and GI tract,
   c. subacute diffuse, necrotizing glomerulonephritis leading to uremia;
(2) "Uremic" pneumonitis;
(3) "Uremic" fibrinous pericarditis;
(4) Pleural effusions, bilateral;
(5) Acute massive lower intestinal hemorrhage secondary to focal necrotizing vasculitis of terminal ileum and cecum; and
(6) Status postoperative 23 days resection of middle lobe of right lung.

Differential Diagnosis. *Doctor Bauman:* Fulfilling the criteria set forth by Godman and Churg[1], in 1954, of necrotizing respiratory tract granulomata, necrotizing vasculitis and glomerulitis, this case is diagnosed as Wegener's granulomatosis. The diagnosis of Wegener's granulomatosis was first strongly considered in this 46-year-old man upon the finding of necrotizing granulomatous lesions associated with a necrotizing vasculitis in the middle lobe of the right lung resected about three weeks prior to the patient's death. Appropriate culture studies and special histologic staining techniques ruled out specific granulomatous diseases such as sarcoidosis, tuberculosis, histoplasmosis, and

blastomycosis. The subsequent rapid rise of the patient's blood urea nitrogen to over 200 mg/100 ml tended further to confirm the diagnosis of Wegener's granulomatosis.

The basic underlying cause of the patient's death was renal failure with uremia resulting from subacute diffuse necrotizing glomerulonephritis. His sudden death was precipitated by massive hemorrhage in the lower intestine originating from focal mucosal ulcerations and infarcts associated with necrotizing vascular lesions in the terminal ileum and cecum.

This case is somewhat unusual in the respect that the respiratory component of the disease appeared to be confined entirely to the right middle lobe resected three weeks prior to the patient's death. Walton[2] in his retrospective survey of 56 cases of Wegener's granulomatosis found that two-thirds of the cases suffered from sinus, nasal, or other upper respiratory lesions of the disease and in the remaining one-third pulmonary signs and symptoms were the presenting feature.

Autopsy studies in this case failed to reveal any additional necrotizing granulomata or vascular lesions in the lungs. However, one must take consideration of the fact that this patient received adrenal corticosteroid therapy during the last two weeks of life and that perhaps the pulmonary and other visceral lesions of Wegener's granulomatosis may have been ameliorated somewhat. Steroid therapy was started with little hope that such therapy would be efficacious; however, there is a recent report in the literature[3] of a patient with Wegener's granulomatosis who was treated with steroids on a long-term basis and survived at least 4½ years from onset until death occurred in an uncontrollable exacerbation of the disease process. This is believed to be the longest recorded survival.

In view of the focal vascular and ulcerative lesions found in the lower intestinal tract at autopsy it is of interest to consider that the rectal fistula surgically excised about three months before the patient's death may have been associated with Wegener's granulomatosis; however, the rectal fistula probably was an unrelated separate disease entity since review of the slides of the excised margins of the fistula tract revealed only acutely and chronically inflamed tissue with foreign-body type granulomatous inflammatory reaction with no associated vascular lesions.

Comment. *Doctor Bauman:* Wegener's granulomatosis is a rare, uniformly fatal disease of unknown etiology, most of the patients dying of renal failure within five months.[2] The clinical condition was originally described by Klinger in 1931, but Wegener in 1936 and 1939 reported further cases and first included an account of its pathology. From his reports the eponym, Wegener's granulomatosis, originated. Only about 100 cases have been reported in the world medical literature up to 1962. The disease has been referred to as a respiratory-renal type of polyarteritis nodosa. There is some insecurity in considering the anatomic trilogy of necrotizing vasculitis, pulmonary granulomata, and glomerulonephritis as a separate disease entity. The question has been posed[4] as to whether periarteritis nodosa, Wegener's granulomatosis, lethal midline granulomatosis, hypersensitivity angiitis, rheumatoid arthritis, Löffler's syndrome, eosinophilic granuloma, and allergic granulomatosis are really separate disease entities or whether they represent varying manifestations of a similar or the same disease process.

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PRODUCTS OF RESEARCH THAT SAVE LIVES. Let the law deal harshly with any dishonesty, false claims, or unsafe practices found in the drug industry, but let us not encourage unlimited power by the FDA which could destroy the tree laden with the fruit of honest research because of one ailing branch. We would suggest . . . a resolution of confidence in the pharmaceutical industry whose products have saved the lives of so many children. It is easy to forget that the life of President Lincoln's son could probably have been saved by antibiotics.—ROBERT F. LORENZEN, M.D., in *Arizona Medicine*, 21: 469, (June) 1964.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
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Newer Antidepressant Drugs: Desipramine and Nortriptyline

By RICHARD I. H. WANG, Ph.D., M.D., Milwaukee, Wisconsin

■ TREATMENT OF patients suffering from mental depression has been a challenge to the practicing physician for many years. One of the difficulties has been the paucity of safe and effective therapeutic measures. Due to contraindications and the lack of long lasting benefit, the electroconvulsive therapy which has been utilized in the past is gradually being replaced by drug treatment, supportive measures, and psychotherapy. Recently, two new drugs, desipramine and nortriptyline, were introduced for the treatment of mental depression. Thus it is appropriate at this time to review the current therapy of depression.

The clinical features of depression are exhibited by patients who show despondency and suffer from lack of energy, interest, ambition, and concentration. These individuals may also present complaints of anorexia, insomnia, lethargy, depression of libido, constipation, anxiety, and nervousness. Feelings of guilt and unworthiness, paranoid delusions, delusions about physical health and bodily function, and suicidal thoughts may appear at some period of their illness.

The difficulty in evaluating a new drug for the therapy of mental depression is exemplified by conflicting reports regarding the effectiveness of various antidepressant drugs. Numerous factors may account for the discrepancy of results among investigators. First, the clinical evaluation of antidepressant agents resembles that of analgesic drugs in that the high frequency of placebo response complicates interpretation of results. Second, spontaneous remission of mental depression is not unusual. Third, the lack of a universally recognized classification of depression makes it difficult to compare studies which have utilized heterogenous clinical materials.

The currently used antidepressant agents can be classified as follows:

I. MINOR ANTIDEPRESSANTS
- A. *Sympathomimetics*
  amphetamine, dextroamphetamine, methamphetamine, phenmetrazine (Preludin)
- B. *Marginal Sympathomimetics*
  methylphenidate (Ritalin)
  pipradol (Meratran)

II. MAJOR ANTIDEPRESSANTS
- A. *Monoamine Oxidase Inhibitors*
  isocarboxazide (Marplan)
  nialamide (Niamid)
  phenelzine (Nardil)
  tranylcypromine (Parnate)
- B. *Iminodibenzyl Derivatives*
  imipramine (Tofranil)
  desipramine (Norpramin, Pertofrane)
  amitriptyline (Elavil)
  nortriptyline (Aventyl)

Major antidepressants of the iminodibenzyl group are, at present, the most commonly employed agents for the treatment of mental depression. They are more effective than the minor antidepressants and are less toxic than the monoamine oxidase inhibitors.

The toxicity of monoamine oxidase inhibitors (MAOI) appears to be proportional to

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their antidepressant potency. Due to the possible dangers of hypertensive crisis, hepatic necrosis and agranulocytosis, potent MAOI such as tranylcypromine are reserved for acutely suicidal and severely depressed cases. However, in view of their ability to potentiate the effects of many drugs including sedatives, stimulants, histamine and epinephrine, the routine use of MAOI should be discouraged.

The iminodibenzyl derivatives do not inhibit monoamine oxidase; their mechanism of action is unknown. They have a weak atropine-like action and their side effects thus include dryness of mouth, tachycardia, blurred vision and constipation. They should therefore be used with caution in patients who are prone to develop urinary retention and in certain glaucomatous patients.

The two new antidepressant drugs both belong to this class of iminodibenzyl derivatives. In vivo, imipramine is demethylated to form desipramine. The latter is believed to be the active principle of the drug. Likewise, demethylation of amitriptyline forms nortriptyline (Fig 1). Both desipramine and nortriptyline are superior to their parent compounds in having a more rapid onset of therapeutic action. Beneficial results in depressed patients may be detected as early as 36 hours following the initial medication with desipramine or nortriptyline. Interestingly, the iminodibenzyl derivatives can also produce sedation and drowsiness. These symptoms are more prominent with the amitriptyline-nortriptyline group than with the imipramine-desipramine group. In a great many cases, these represent side effects; however, depressed patients with severe anxiety, restlessness, and nervousness may benefit from the sedation produced by the amitriptyline-nortriptyline group. Drowsiness and dryness of mouth appear to be more prominent with nortriptyline than desipramine.

The usual dose of desipramine is 25 mg three times daily, that of nortriptyline is 10 mg three times daily. If there is no significant improvement, the total dosage of either drug can be doubled in divided doses. In using desipramine should nervousness and insomnia develop, a sedative or a minor tranquilizer like meprobamate or chlordiazepoxide may be added, or the evening dose of desipramine can be substituted by nortriptyline.

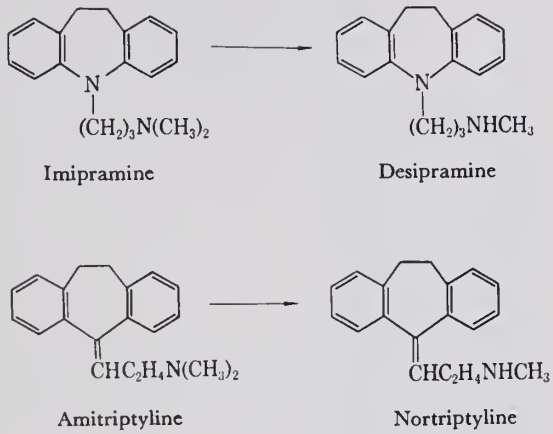

Fig. 1—Structural formulae of imipramine, desipramine, amitriptyline, and nortriptyline.

If a depressed patient fails to respond to desipramine, he will probably not respond to other members of the iminodibenzyl group. Thus, the use of desipramine can serve as a therapeutic trial to determine which patients will be benefited by the iminodibenzyl derivatives and which patients will require MAOI or electroconvulsive therapy. Nortriptyline, on the other hand, is claimed to be of benefit in various disorders, ranging from schizophrenia to depression; this probably reflects the relatively prominent sedative-tranquilizing component of its action.

The iminodibenzyl derivatives should never be used concomitantly with the monoamine oxidase inhibitors since combination of the two groups of antidepressant drugs have resulted in severe toxic reactions and death. There should therefore be a cessation of antidepressant therapy for at least one week in switching therapy from an agent of one group to an agent of the other group.

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W. P. CURRAN, M.D.
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Work Week of Health

■ IT WAS MY DUTY and pleasure to have participated in the third annual Wisconsin Work Week of Health presented February 22 through February 26 at the State Medical Society headquarters in Madison. For those of you who did not have an opportunity to attend, let me say that it was a real thrill and of some surprise for me to witness the intense interest shown by these people who are in fields other than Medicine.

The program included a diversity of topics, and at no time during the entire week was there a matter under discussion which could be classified as "dull." All of the programs were outstanding and well attended as registration figures indicated. Total attendance was 1,380, more than 100 over last year's total.

The program on Rural Health was informative and impressive with attendance by those whose full-time occupation is agriculture. The session on the Mentally Retarded Child was well presented, and it drew an overflow crowd for the President's Room which seats a maximum of 265. Speeches were transmitted via the intercom system to adjoining rooms, the Council Room, and the Dining Room.

The program devoted to Emergency Room Care in Hospitals also received considerable attention and interest. At the conclusion of the presentations, the entire audience was divided into four groups, each group meeting in a separate room with a moderator. Each group had its own question, answer, and discussion period. A good deal was learned of the many problems encountered in our hospitals throughout the State in the operation of their Emergency Room Service. Following the group discussions, the entire assembly reconvened for a collective summary by the moderators of the groups. It is difficult to express how interested and pleased this audience was with the entire day's program.

The largest enrollment for a single day's session was recorded on the final day which dealt with Commitment Proceedings of the Mentally Ill. This session was well moderated; and with discussions by jurists from the State of Wisconsin and representatives of the mental hospitals in Wisconsin, it developed into a very informative session for everyone.

I cannot compliment the Staff of the Medical Society sufficiently on the courteous manner in which they carried out their duties during this session. They were efficient, courteous, and really put themselves out to handle this large group of people—the conducted tours throughout the Society building, the handling of the feeding of these people, and the promptness in which the meetings began and ended. I do not believe there was a discrepancy of more than five minutes on the starting and ending time of any of the programs.

While in this vein of thought, congratulations are due our Secretary-General Manager, Mr. Charles Crownhart, who fostered and nurtured this Work Week of Health from its inception. He will be glad to hear the numerous compliments, paid to our State Society for the excellent programs, made by out-of-state speakers from such areas as Washington, D.C.; Evansville, Ind.; Chicago, Ill.; Minnesota; Iowa; and Michigan. They had never experienced participation in such a session with the result that they were going back to their respective areas to express their feelings of the good public relations service demonstrated by the State Medical Society of Wisconsin. I, too, have received numerous complimentary letters from members of the Bar and Clergy who were present during the week.

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H. J. Kief, M. D._____Fond du Lac
R. W. Mason, M. D._____Marshfield
R. C. Frank, M. D._____Eau Claire
V. E. Ekblad, M. D._____Superior
L. J. Van Hecke, M. D._____Milwaukee
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George Nadeau, M. D._____Green Bay

W. J. Egan, M. D._____Milwaukee
Past President

EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Progress in Arthritis

LAST OCTOBER, the principal voluntary health agencies in the field of arthritis united to form a new organization, to be called "The Arthritis Foundation." The 78 existing chapters of the old Arthritis and Rheumatism Foundation formed the nucleus of the new body, while the arthritis activities of the National Foundation have been transferred to it, leaving the latter free to devote all its energies to birth defects and virus diseases. The nationwide network of arthritis clinics operated by the National Foundation will gradually be turned over to the new Arthritis Foundation.

The Foundation will devote itself to programs to prevent crippling and to rehabilitate arthritis victims. In addition it will support research aimed at controlling the effects of arthritis and eventually finding its cause.

Those familiar with the work done in the field of arthritis congratulate the Arthritis Foundation and its president, Dr. William S. Clark, a recognized scientist and clinician, and wish them well. It is interesting to note that the new organization has set an immediate goal of $10 million in order to place diagnostic and treatment facilities within reach of every patient.

Ten million dollars for the scientific treatment and rehabilitation of arthritic sufferers doesn't seem so much compared to the $250 million these same sufferers spend on quack remedies and false cures. —D.N.G.

AMA June Convention—New York

THE YEAR 1965 is a crucial year for American medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America.

An outstanding highlight in medicine in 1965 will be the 114th annual convention of the American Medical Association June 20–24 in New York City. It is our conservative estimate that more than 10 per cent of all American physicians, and perhaps as many as 15 per cent of those in private practice, will register for the New York convention.

Nowhere else in the entire world do physicians gather in such numbers to continue their medical education in an intensive short course that, literally, has something for everyone. Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians do not attend the AMA annual convention just to take a trip to New York, although that is an interesting sidelight. They attend because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.

—DONOVAN F. WARD, M.D.
President, American Medical Association

MENTAL RETARDATION GRANT

The Joseph P. Kennedy Jr. Foundation has provided $20,000 to the University of Wisconsin to help develop an application for federal support of a proposed University-wide mental retardation center.

The grant was announced February 2 by UW Pres. Fred Harvey Harrington.

The application would seek federal funds under Public Law 88–164. This provides funds for construction of buildings to house clinical and research projects of distinguished scientists working in mental retardation.

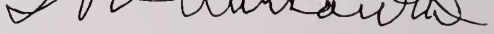
The center would bring together existing programs from many areas of the University. Two such programs are Dr. Harry Waisman's work in the Joseph P. Kennedy Jr. Laboratories and the Training Center in Mental Retardation sponsored by the Vocational Rehabilitation Administration.

In addition, the center would offer diagnosis, treatment, and outpatient services. An experimental laboratory school would provide research opportunities and training programs for professional personnel.

PRESIDENT'S PAGE *continued from page 144*

Particular credit and thanks, too, should be given the 34 cooperating agencies who assisted the State Medical Society in presenting the programs. Their valuable assistance and knowledgable concern in the areas discussed played a significant role in the success of the Work Week of Health.

This function will continue to be provided the people of the State of Wisconsin on an annual basis; and it is my hope that more physicians, who are now conspicuous by their absence, will participate in the years ahead. Public relations-wise, it is doing the medical profession a tremendous amount of good; and exposure of the individual representatives of Medicine in our State to the lay people at these meetings would also help Medicine, public relations-wise.



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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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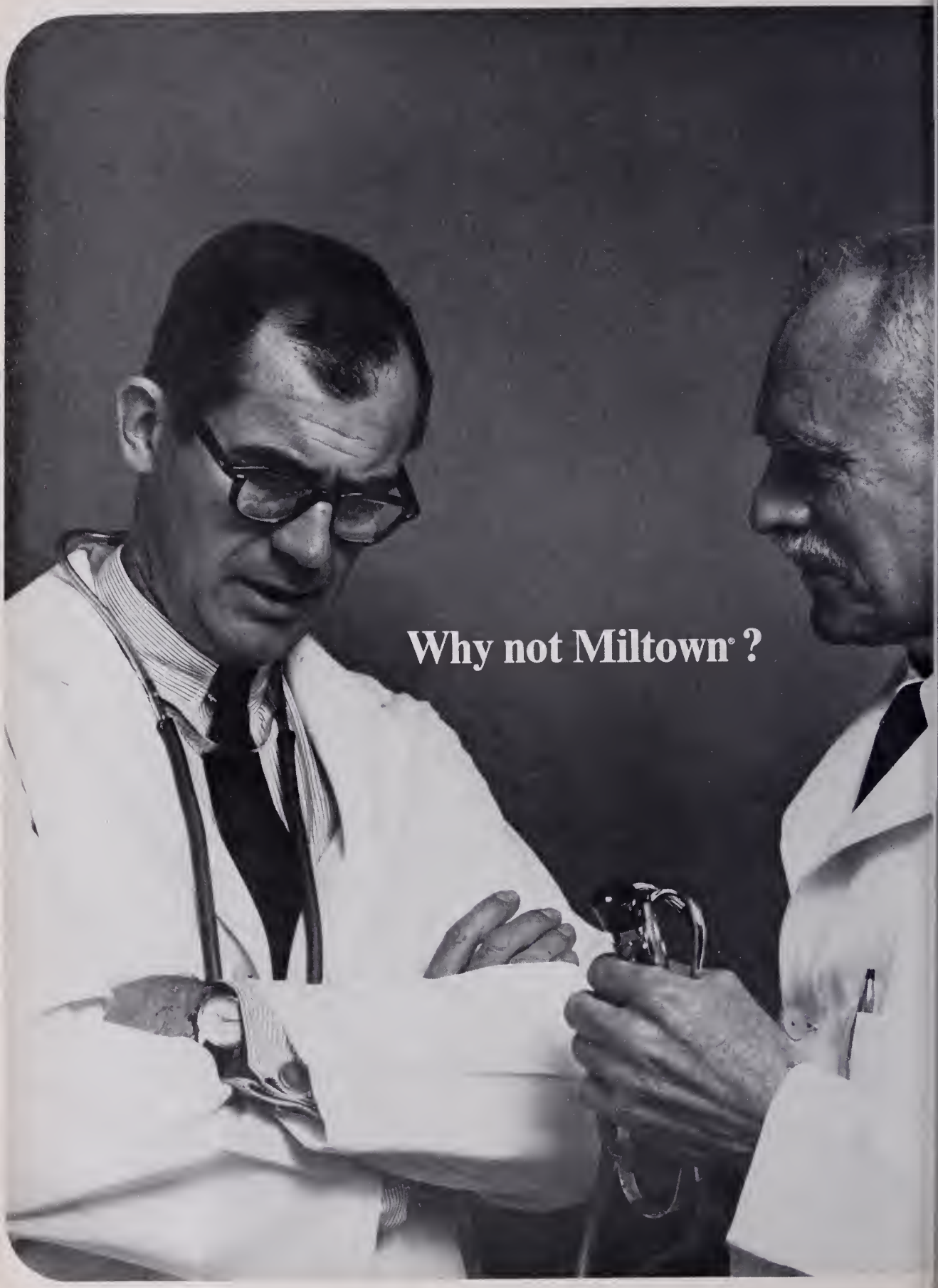
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COUNTY SOCIETY PROCEEDINGS

BROWN

A motion picture depicting life in certain areas of Africa, with details on medical care available in those areas, was shown at the February meeting of the Brown County Medical Society in Green Bay's Northland Hotel. Particularly striking was the performance of a craniotomy by a group of native witch doctors.

During the business session which preceded the movie, *Dr. J. E. Dettmann* was appointed to speak on the subject of medicare at a meeting of the Brown County Medical Assistants, in answer to a request from Mrs. Lola Lasuer that the Society provide a speaker.

A motion by *Dr. J. B. Grace*, who investigated the program, was approved that the Society sponsor a project to promote use of a medical emergency identification tag in Brown County.

Community mental health resources in Brown County were discussed by a panel for which Carl T. Bruno served as moderator at the March 11 meeting of the Brown County Medical Society in Green Bay's Downtowner Motel.

Mr. Bruno is community service supervisor of the Green Bay district office of the Division for Children and Youth, Wisconsin State Board of Public Welfare. On the panel with him were John Wood of the Brown County Welfare Department, Robert Allen, director of the Sheltered Workshop, Walter Weaver, administrator of the Brown County Guidance Clinic, and Ted Dettweiler district consultant, Community Mental Health Services, Green Bay.

A new member of the Society is Dr. Jeremy R. Green.

DANE

Meeting March 9 at State Medical Society headquarters, Madison, members of the Dane County Medical Society heard *Dr. William B. Gallagher* of La Crosse discuss his experiences on the S. S. HOPE. On Aug. 25, 1962, Doctor Gallagher left his private practice to begin 10 months of volunteer service on the White Hospital Ship Hope at Trujillo, Peru. During its mission in Peru, Doctor Gallagher said, the S. S. HOPE medical personnel touched 80,000 Peruvians directly and approximately a half million indirectly. Such medical service was incidental to the special training given some 600 Peruvian medical workers, including native physicians, nurses, medical students, and technicians.

New members of the Society are *Drs. Harold E. Booker, Stephan Epstein, Theodore C. Feierabend, Charles H. Miller, III, Gustave C. Mueller,* and *Jack H. Petajan.*

DOUGLAS

Douglas County Medical Society's participation in the county school immunization program was announced at the Society's February 3 meeting at Superior. Also announced was a donation to the CES Foundation by the Society in memory of two recently deceased physicians, Drs. Earl E. Carpenter and Joseph H. Weisberg. A new member of the Society is *Dr. Robert L. Sellers*. On the program was the Medifilm VI report on the annual AMA meeting in San Francisco.

Physicians whose names appear in italics are members of the State Medical Society.

KENOSHA

The Kenosha County Medical Society met for dinner March 4 in Kenosha. The program was a panel discussion of current federal medical care for aged legislation.

MILWAUKEE

Dr. Simon Kramer, Philadelphia, an authority on radiation treatment of cancer, addressed The Medical Society of Milwaukee County March 11 in Milwaukee. The Society sponsored Doctor Kramer's four-day visit to Milwaukee for a series of talks and conferences. He is professor of radiology at Jefferson Medical School and chief of the division of radiation therapy at the Jefferson Medical Center.

OZAUKEE

For the first time in several years, the Ozaukee County Medical Society joined the Ozaukee County Bar Association for a dinner-meeting March 18 at Port Washington. Guest speaker was Lyall T. Beggs, Madison, president of the State Bar of Wisconsin. Wives of members of the two groups were invited to attend.

PIERCE–ST. CROIX

Some 20 members of the Woman's Auxiliary to the Pierce-St. Croix County Medical Society were guests of their husbands at the Society's monthly meeting February 16.

Guest speaker for the dinner meeting was Glenn Waldschmidt, Rothschild, regional representative of the State Medical Society. Mr. Waldschmidt compared the Eldercare plan to medicare, citing the greater benefits it would offer the aged, the lower costs of administering the plan, and its more fair way of obtaining funds.

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References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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SPECIALTY SOCIETY PROCEEDINGS

Central Surgery Association

A proposal that the county institutions in Wauwatosa be made the nucleus for one of 32 regional medical centers in the country suggested by President Lyndon B. Johnson was made by Milwaukee County Executive Doyne March 4 in Milwaukee at the 22nd annual meeting of the Central Surgery Association.

The program opened with a clinic day at Milwaukee County General Hospital arranged by the Department of Surgery of Marquette University School of Medicine, Milwaukee. Sessions of the three-day meeting were also held at the Hotel Schroeder.

During the election of officers, Dr. D. Emerick Szilagyi, head of a surgical division of Henry Ford Hospital, Detroit, was named president-elect of the association. Incoming president is Dr. Carl E. Lischer, associate professor of clinical surgery at Washington University, St. Louis. *Dr. Edwin H. Ellison*, professor and chairman of Marquette's Department of Surgery, was retained as secretary. Also elected were Dr. Everett L. Strohl, Chicago, clinical associate professor of surgery at the University of Illinois, treasurer, and Dr. Oliver H. Beahrs, associate professor of surgery at the Mayo Foundation, Rochester, Minn., councilor.

Milwaukee Dietetic Association

In order to provide people with correct, scientific answers to their questions about nutrition and diet, the Milwaukee Dietetic Association established a telephone answering service in January. Called "Dial-A-Dietitian," the free public service is provided by 50 qualified dietitians on a rotating daily basis. It has the approval of The Medical Society of Milwaukee County.

State Medical Assistants

An audience of approximately 200 heard Paul Mundie, Ph.D., Milwaukee psychologist, discuss the topic, "Understanding the Other Person," on February 6 when the Wisconsin State Medical Assistants Society held its sixth annual educational symposium at State Medical Society headquarters in Madison. A second speaker, Leonard Berry of St. Louis, Mo., presented a talk on communications, and a panel discussion was held on The Health Assistance Payment Act. Mrs. Aleen Piepenburg, Waukesha, state president, extended the welcome.

Milwaukee Oto-Ophthalmic Society

On the scientific program for the March dinner meeting of the Milwaukee Oto-Ophthalmic Society March 23 at the University Club of Milwaukee were *Dr. Glen E. McCormick*, Milwaukee, who presented a case report, and Dr. William H. Saunders, Columbus, O., who spoke on the subject, "Viral Affections of Certain Cranial Nerves." Doctor Saunders is professor and chairman of the department of otolaryngology at Ohio State University Medical School.

Physicians whose names appear in italics are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS *continued*

RACINE

The Racine County Medical Society held a dinner-meeting March 18 at Racine.

WINNEBAGO

Recent advances in hepatitis were discussed by Dr. A. H. Holmes, assistant professor of medicine at the University of Illinois College of Medicine, at the March 4 meeting of the Winnebago County Medical Association in Neenah.

Members heard Doctor Holmes explain the problems of research and how it has been speeded by use of the marmoset as an experimental animal. Blood transfusions should be used only when necessary, the speaker warned, citing the high percentage of hepatitis cases caused by unnecessary transfusions. At present there are no drugs that will lower the incidence of hepatitis, Doctor Holmes observed.

WOOD

Dr. K. V. Gandhi, Marshfield, a new member of the Society, was the speaker February 11 when the Wood County Medical Society met in Marshfield. Doctor Gandhi gave a talk illustrated with slides on the subject of otosclerosis, and showed a movie on the stapedectomy procedure. Discussants were Doctors Gandhi and *A. M. Kinkella*.

New members in addition to Doctor Gandhi are *Drs. W. J. Holtey* and *S. E. Silvis*, Marshfield, and *Dr. William Allen*, Wisconsin Rapids.

During the business session, *Dr. R. W. Mason* discussed Eldercare, the Work Week of Health, and the possibility of forming a Woman's Auxiliary. Glenn Waldschmidt, the State Medical Society's regional representative, spoke on the topic, "Operation Hometown."

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NEWS OF WISCONSIN PHYSICIANS

Dr. Hofmeister Participates

Dr. Frederick J. Hofmeister, Milwaukee, served as moderator for one of the luncheon seminars which were a feature of the 21st annual meeting of the American Society for the Study of Sterility April 2–4 in San Francisco.

Dr. Demergian Returns

After spending the preceding year in private practice in Los Angeles, Dr. Vaughn Demergian has rejoined the staff of the Jackson Clinic in Madison as head of the department of plastic and reconstructive surgery.

Dr. Docter Joins Son

A pediatrician in Racine for 44 years, *Dr. John C. Docter* has left that city to assist his son, *Dr. C. W. Docter,* at Plum City. Doctor Docter has practiced for more than 50 years and last year was made a member of the 50-Year-Club of the State Medical Society.

Dr. Vermund ACR Fellow

Dr. Halvor Vermund, Madison, professor of radiology at the University of Wisconsin Medical School, was among the radiologists who were made fellows of the American College of Radiology at its 42nd annual convocation in February at Philadelphia.

Fellowship to Dr. McRoberts' Son

Robert L. McRoberts, a junior at Yale University School of Medicine and the son of Sheboygan surgeon *Dr. Jerry W. McRoberts,* has been awarded a $1,163 fellowship which will permit him to assist at an African mission hospital for a 10-week period beginning in June. He will work at the Methodist Mission Hospital in Ganta, Liberia. McRoberts is one of 28 American medical students selected by the Association of American Medical Colleges to receive a Smith Kline & French Laboratories foreign fellowship.

Dr. Graves Joins Clinic

After five and a half years of practice in Campbellsport, *Dr. Richard H. Graves* has joined the East Madison Clinic as a general practitioner.

Dr. Glenn to Port Edwards

Dr. E. C. Glenn has moved his medical practice from Wisconsin Rapids to Port Edwards. *Dr. L. R. Pfeiffer,* who had maintained offices at Port Edwards and in Nekoosa for several years, since January 1 has been practicing medicine only in Nekoosa with his partner, *Dr. John E. Thompson.*

Dr. Walker Joins Rio Clinic

Dr. John P. Walker, former Mondovi physician, opened a medical practice in the Rio Clinic in February. Prior to coming to Rio he had been a physician for a short time at Wisconsin State Prison at Waupun.

Hartford Doctors Join Practices

A merger of medical practices was announced in January by *Drs. V. V. Quandt, W. C. P. Hoffman,* and *George Arrambide* of Hartford. Doctors Arrambide and Hoffman merged practices last year and Doctor Quandt joined them January 1.

Dr. Jumes at Sheboygan

Dr. Marvin Jumes, anesthesiologist, announced establishment of a private practice in Sheboygan in February. A 1958 graduate of the University of Wisconsin Medical School, he interned at St. Joseph's Hospital, Marshfield, spent two years in residency at Wisconsin General Hospital, Madison, and served for two years with the U.S. Air Force.

Dr. Settlage to Crivitz

Dr. Henry A. Settlage of Waukesha will move to Crivitz May 1.

Installed as ACOG Fellows

Drs. C. F. Dungar, Appleton; *J. L. Claude,* Oconomowoc, and *J. N. O'Brien,* Janesville, were among the Wisconsin physicians installed as fellows of the American College of Obstetricians and Gynecologists at its annual meeting April 4–8 in San Francisco.

ACP Elects 11 from State

Eleven Wisconsin physicians were elected last year at Philadelphia to the American College of Physicians. Elected fellows were *Drs. L. T. Giles* and *W. B. Parsons, Jr.,* Madison; *F. N. Lohrenz, J. W. Manier,* and *L. L. Schloesser,* Marshfield, and *H. J. Kanin,* Fox Point.

Elected associates were *Drs. J. A. Szweda,* Beaver Dam; *G. E. Owen,* Eau Claire; *P. L. Davidson* and *M. M. Zolot,* Madison, and *W. G. Longe,* Elm Grove.

Dr. La Ham Resumes Practice

Dr. J. T. La Ham resumed practice in Ripon February 15.

Drs. Porter, Hughes Named Fellows

Dr. G. E. Porter, Marshfield, and *Dr. J. B. Hughes,* Oshkosh, were among the 313 pediatricians

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elected to fellowship in the American Academy of Pediatrics at its annual meeting in New York City late in 1964.

Dr. Rupple Admitted to AAOO

Dr. J. H. Rupple, Fond du Lac, was admitted to the American Academy of Ophthalmology and Otolaryngology at the annual meeting in Chicago last fall. He completed qualifications for entering the Academy when he was certified as a diplomate of the American Board of Ophthalmology in New York City in October 1963.

Dr. Wong Heads Drive

Dr. J. R. Wong has again been named chairman of the Heart Fund Drive in Prairie du Chien.

Physicians Reelected to Club

Dr. L. W. Picotte, Chippewa Falls, was reelected to head the Chippewa County Blood Donor Club for 1965 at a meeting of the executive committee held early in December at Chippewa Falls. Other physicians reelected to office in the club were *Dr. C. E. Zenner*, Cadott, vice-chairman, and *Dr. C. B. Hatleberg*, Chippewa Falls, treasurer.

Park Falls Physicians Move

Drs. J. L. Murphy and *E. T. Eyvindsson* moved to a new Medical Building in Park Falls at the end of 1964.

Marshfield Clinic Elects Officers

July 1 is the date set for completion of the entire building project of the Marshfield Clinic, but on February 1 physicians at the Clinc began moving into the new three-story addition.

The move was discussed at the annual meeting of Clinic stockholders and directors in January, when officers were elected. *Dr. G. S. Custer* was reelected president, *Dr. B. R. Lawton* was elected vice-president, *Dr. D. P. Pederson*, secretary, and *Dr. C. A. Vedder*, treasurer.

New Oshkosh Clinic Open

The Oshkosh Clinic Building, an Oshkosh institution since 1919, has had a new location since January 25. Occupants of the new two-story brick and redwood building are *Drs. M. H. Steen, T. M. Kivlin, R. V. Kuhn, W. E. Clark, B. S. Greenwood, J. T. Petersik, E. F. Cummings*, R. W. Roberts, Harvey Monday, H. J. Danforth, and *C. H. Behnke*, all of Oshkosh, and *Drs. S. R. Beatty, R. F. Douglas*, and *D. J. Ryan*, Neenah.

Group Opening New Clinic

On July 1, a group of six physicians who now maintain a partnership at a Milwaukee address will move into a $250,000 medical clinic on the site of the old E. R. Godfrey mansion in Wauwatosa, which

was razed last summer to make way for the new building.

To be known as Harwood Medical Associates, the group of physicians includes *Dr. Einar R. Daniels*, chief of staff at Milwaukee Hospital, who is head of the group, and *Drs. C. L. Junkerman, J. K. Olinger, W. L. Deardorff, J. S. Ziolkowski*, and *F. E. Murray*.

Fraternity Honors Dr. Finlayson

Dr. William E. Finlayson, Milwaukee physician, was named Milwaukee man of the year in December by Delta Chi Lambda chapter, Alpha Phi Alpha fraternity. Doctor Finlayson, the chapter's retiring president, was chosen for service to the community.

Dr. Kief Participates

Dr. H. J. Kief, Fond du Lac city health officer, participated in a food personnel and public health institute held March 8 in Fond du Lac under the sponsorship of the Hotel and Restaurant Division of the Wisconsin State Board of Health in cooperation with the Fond du Lac City Health Department.

Dr. Currie Named

Dr. R. E. Currie, St. Catherine's Hospital, was named physician chairman of non-soliciting units for the 1965 Heart Fund Drive in Kenosha.

Dr. Narodick Elected

Dr. Benjamin G. Narodick, Milwaukee, has been elected to the board of the Wisconsin Anti-Tuberculosis Association.

Club Honors Dr. Weinshel

The Variety Club of Wisconsin and its women's organization honored *Dr. Leo R. Weinshel* as its "man of the year" at a dinner February 20 at the Pfister Hotel, Milwaukee. Doctor Weinshel, who is commander of the 452nd General Hospital, a Milwaukee Reserve unit, was honored for charitable activities.

Dr. Hahn Honored

Dr. Anthony C. Hahn, well known Watertown physician, was honored at a reception and breakfast February 11 at Watertown Memorial Hospital. Given by the hospital's medical staff, who presented him with a plaque, the event was in recognition of Doctor Hahn's retirement from practice. The presentation was made by the Rev. Thorlief Harberg, who delivered a brief and inspiring address. *Dr. E. P. Schuh*, hospital chief of staff, also spoke.

Dr. Cotts Receives Award

Dr. Lloyd R. Cotts, Rice Lake, was awarded the distinguished service award of the Rice Lake Junior Association of Commerce in February.

Dr. McCracken 93

Dr. Richard W. McCracken, veteran Union Grove physician, observed his 93rd birthday February 4. Doctor McCracken opened his office in Union Grove in 1896. In April 1951, a testimonial dinner and program were held in Union Grove to mark his 55 years of medical practice in that community, with several hundred former patients, friends, and colleagues in attendance. Doctor McCracken served several terms as president of the Racine County Medical Society.

Attend Graduate Courses

Dr. S. R. Osicka, who has been associated with *Dr. L. J. Seward* for the past year in Berlin, attended a postgraduate session on cardiology and

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PHYSICIANS SPEAK AROUND THE STATE

Dr. William F. Kennedy, Neenah orthopedic surgeon, to Neenah Homemakers Club, March 10, illustrated talk on modern orthopedics.

Dr. Claude Schmidt, Waukesha obstetrician and gynecologist, to Waukesha county educators, March 8, explained that cases of pregnancy among schoolgirls are characterized by "emotional poverty"—a lack of love and communication between parent and child.

Dr. G. Daniel Miller, chief of anesthesiology at Oconomowoc Memorial Hospital, and *Dr. Kenneth R. Fick*, Watertown, to Watertown Memorial Hospital Auxiliary, March 1, talks on latest developments in field of anesthesiology.

Dr. George J. Schroth, Wausau obstetrician and gynecologist, to Wausau Woman's Club, January 25, talk on hypnosis in medicine.

Dr. Hugh J. McLane, Fond du Lac, to Chapter K, P.E.O. Sisterhood, February 19 in Fond du Lac, "Down the Widening Path to Health," talk emphasizing subject of heart disease.

Dr. Robert Samp, University of Wisconsin Medical School professor of clinical oncology, to 500 delegates to American Family Insurance Company conference, March 6 in Madison, called for moderation and simplicity in daily living.

Dr. F. A. Melms, Jr., Menomonie, to Menomonie Rotary Club, March 3, explained provisions of Eldercare.

Dr. Nathan E. Bear, president of Green County Hospital Board of Trustees, to Green County Shrine Club January 26 in Monroe.

Dr. Frederick L. Schaefer, Neenah-Menasha obstetrician and gynecologist, to Neenah Junior Women's Club in January, talk on cancer illustrated by a film, "Time and Two Women."

Dr. H. Kent Tenney, Madison, at first of educational series for "Concerned Parents" presented every Tuesday in February under co-sponsorship of Outagamie County Mental Health Association and Appleton Jaycettes, February 2 at Appleton, called trust most important single factor in relationship between parent and child.

Drs. Harold Wagner and Hugh Wilson, pathologists at St. Catherine's Hospital, Kenosha, and consultants to Wisconsin State Crime Laboratory, Madison, to Midwestern Conference of Wisconsin District Attorneys Association, January 27 in Milwaukee, on subject, "The Pathologist and Investigation of Apparent Violent Deaths."

Dr. Bruce V. Winter, Union Grove, vice-president of Racine Health Fund, which sponsored the clinic, at each evening session of five-day Stop Smoking program conducted in January at St. Luke's Hospital, Racine, on psychological factors in smoking.

Dr. Ralph C. Frank, Eau Claire radiologist and past president and chairman of board of directors of Wisconsin Division, American Cancer Society, headline speaker January 25–26 for Eau Claire area cancer crusade.

Dr. Antoine Barrette, Peshtigo, and *Dr. K. G. Pinegar*, Marinette, at meeting of Tri-County Safety Council January 14 in Marinette, talks on "The Physician's Role in Safety."

electrocardiogram interpretation in January at the University of Minnesota. From January 11 to 15, Doctor Seward attended an educational session on physiology at the University of Michigan.

Staff Donates Pacemaker

A Cardiac Pacemaker Monitor has been donated to Community Memorial Hospital, Oconto Falls, by the hospital's medical staff. Members include *Drs. K. L. Strebe, J. R. Culver*, and *C. E. Siefert*, Oconto Falls, and *Dr. F. W. Klutzow*, Gillett.

Doctors Conduct Panel

Dr. M. H. Olson, Schofield, as moderator, *Drs. F. C. Johnson* and *W. T. Becker*, Wausau, and *Dr. H. A. Schulz*, Edgar, conducted a panel discussion following presentation of the movie, "Time and Two Women," shown under sponsorship of the American Cancer Society January 5 over Wausau station WSAU-TV.

Dr. Keepman Co-Hosts Alcoholism Series

Dr. Jay P. Keepman, Madison, member of the Advisory Committee to the Mayor's Commission on Alcoholism, and Bill Patrick of the WIBA staff co-hosted a five-part series on alcoholism which began on the "Viewpoint" program February 28 over Madison station WIBA and WIBA-FM. On March 20, Doctor Keepman and a Madison panel summarized the series and discussed the problems facing Madison in its treatment of alcoholics.

NEW GROUP

MILWAUKEE COUNCIL FOR CHILD PSYCHIATRY

A new group, The Milwaukee Council for Child Psychiatry, has recently been formed to represent the child psychiatrists in the Milwaukee community. The purposes of the Council are: to provide a forum for the discussion of subjects related to the emotional needs of children; to provide the means for the exchange of ideas, relative to the resources and needs of the community; to promote those professions and fields allied to child psychiatry which endeavor to meet the emotional needs of children; to provide for a group which, by nature of its collective skill and experience, can offer such declarations, and/or present such findings which would safeguard recognized established resources or promote the establishment of such practices which would contribute to the mental health of children.

The officers of the Council are: Chairman, *H. David Sackin, M.D.*, 1700 West Wisconsin Avenue, Milwaukee, Wisconsin 53233; Secretary-Treasurer, John R. Altmeyer, M.D., 1121 North Waverly Place, Milwaukee, Wisconsin 53202.

Dr. Buxbaum at Harvard

Dr. Robert Buxbaum, formerly of University Hospitals, Madison, is now at Harvard Medical School, Cambridge, Mass. He is a research associate in preventive medicine at the school and its associated teaching hospitals.

Dr. Eichman Named Assistant Dean

Dr. Peter L. Eichman, director of student health and associate professor of medicine and neurology, has been appointed assistant dean for clinical affairs at the University of Wisconsin Medical School, Madison. He replaces *Dr. Edwin C. Albright*, who resigned from the post Sept. 1, 1964.

Dr. Belson Opens Practice

Dr. Michael J. Belson, 1960 graduate of Marquette University School of Medicine, Milwaukee, has opened a practice in ophthalmology in association with *Drs. E. G. Nadeau, George Nadeau*, and *Robert T. Schmidt* in Green Bay.

Dr. McLaughlin at Sun Prairie

Dr. J. Thomas McLaughlin has joined *Drs. Joseph F. Behrend* and *W. T. Russell* in their offices at Sun Prairie. Doctor McLaughlin, who received his medical degree from the University of California, Berkeley, recently completed his residency at Contra Costa County Hospital, Martinez, Calif.

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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de effects and precautions: The transitory owsiness which may occur with hydroxyzine Cl usually disappears spontaneously in a few ays with continued therapy, or is correctable / dosage reduction. Dryness of the mouth may e seen with higher doses. Involuntary motor tivity has been reported in hospitalized atients on higher than recommended doses. ydroxyzine HCl may potentiate CNS depres- ants, narcotics such as meperidine, barbitu- ates, and anticoagulants. In conjunctive use, osage for these drugs should be decreased. ecause drowsiness may occur, patients should e cautioned against driving a car or operat- g dangerous machinery. **Parenteral Solution recautions and contraindications:** This dosage orm is intended only for I.M. or I.V. adminis- ation and should not, under any circum- ances, be injected subcutaneously or intra- rteriolly. When the usual precautions for I.M. jection have been followed, reports of soft ssue reactions have been rare. I.V. adminis- ation should be slow, no faster than 25 mg. er minute, and should not exceed 100 mg. in ny single dose. Particular care should be used insure injection only into intact veins; a few stances of digital gangrene occurring distal the injection site have been attributed to advertent intraarterial injection or periarte- al extravasation, both of which should be voided. More detailed professional informa- on available on request.

PHYSICIAN NEWS *continued*

Appleton Psychiatrists Appointed

The part-time services of three Appleton psychiatrists, *Drs. D. P. Engstrom, Keith M. Keane,* and *J. B. Weissler,* have been secured by the Outagamie County Community Guidance Center to fill the vacancy created by the resignation as medical director of *Dr. H. G. Cooper,* who is entering private practice in Edmonds, Wash. Doctor Engstrom is serving as part-time medical director and Doctors Keane and Weissler, his associates, also are working at the center on a part-time basis. Their appointments were effective February 1.

Dr. Sun Locates in Wautoma

Dr. Kwoh Cheng Sun, formerly located in Siren, has opened an office for general practice and surgery in Wautoma.

Dr. Meyer Medical Director

Dr. Jules O. Meyer has been named medical director at the American Motors body plant, Milwaukee, after retiring from the U.S. Army Medical Corps with the rank of lieutenant colonel.

Dr. Wilkinson Receives Recognition

Dr. H. E. Wilkinson, director of the Tomah VA Hospital, has been certified and registered as a qualified mental hospital administrator, according to official announcement from the Committee on Certification of Mental Hospital Administrators of the American Psychiatric Association.

Recognition from another source was accorded Doctor Wilkinson in February when he was elected president of the Tomah executive council of the Boy Scouts of America.

UW Receives Grant

James F. Crow, Ph.D., acting dean of the University of Wisconsin Medical School, has announced the award by the National Foundation of another $23,635 to the School for support of a Birth Defects Center. Since the Center was established in 1962 with March of Dimes funds, its staff has studied about 80 different types of birth defects. Dr. John Opitz is the Center's acting director.

Dr. Bouman to Cincinnati

Dr. Harry D. Bouman, professor of physical medicine at the University of Wisconsin since 1947, is now director of the University of Cincinnati's department of physical medicine and rehabilitation.

Dr. Bloodworth Visiting Professor

Dr. J. M. B. Bloodworth, Jr., professor of pathology at the UW Medical School, Madison, was the visiting professor of pathology at the University of Cincinnati Medical Center in late February. He participated in a CPC and presented a talk on his research in diabetes and related vascular disease.

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UW Medical School Adds to Staff

Seven assistant professors have been added to the Department of Surgery staff at the University of Wisconsin Medical School in the past year.

Dr. Henry A. Kubinski has been approved by the University Board of Regents as the first Euretta Mary Kimball Davis professor of neursurgery. Early this year the University received a $62,500 gift from a 1906 alumnus, Ralph E. Davis of Houston, Tex., to provide a two and a half year research professorship in neurosurgery. The University will match the gift. Doctor Kubinski was named to the professorship and will study brain tumors and related conditions.

Besides Doctor Kubinski, assistant professors of surgery appointed in the past year are *Dr. J. R. Benfield*, a thoracic surgeon; *Dr. James H. Brandenburg*, ear surgeon; Dr. Charles A. Tait, audiologist; Dr. Donald H. Wilson, neurosurgeon; Dr. James D. Whiffen, cardiovascular surgeon, and Dr. Charles E. Yale, a general surgeon.

Two assistant professors of anesthesiology have also been named in recent months at the Medical School. Effective January 15 was the appointment of Dr. Phyllis M. Connor. Dr. W. Stuart Sykes was appointed last August.

Dr. Carey Receives Markle Scholarship

A five-year $30,000 Markle scholarship, effective July 1, has been awarded to *Dr. Larry C. Carey*, chief administrative resident in surgery at Milwaukee County General Hospital and an instructor in surgery at Marquette University School of Medicine.

Marquette Receives Easter Seal Grant

Marquette University, Milwaukee, has been awarded a $20,869 grant by the Easter Seal Research Foundation to study why some forms of rickets cannot be treated with vitamin D therapy. Research will be conducted by Dr. Karl Mueller, associate professor of orthopedic surgery, and *Dr. Walter P. Blount*, chairman of the Department of Orthopedic Surgery at Marquette.

Dr. Kimmelstiel Named

Dr. Paul Kimmelstiel, former professor of pathology at Marquette University School of Medicine and director of laboratories at Milwaukee County General Hospital, recently was named research professor of pathology at Marquette. Internationally known for kidney disease research, Doctor Kimmelstiel and a colleague described the kidney disorder known as Kimmelstiel-Wilson disease.

Dr. Bernard Accepts Fellowship

Dr. Victor M. Bernhard, assistant clinical professor of surgery at Marquette University School of Medicine, has accepted a one-year fellowship in vascular surgery financed by the National Heart In-

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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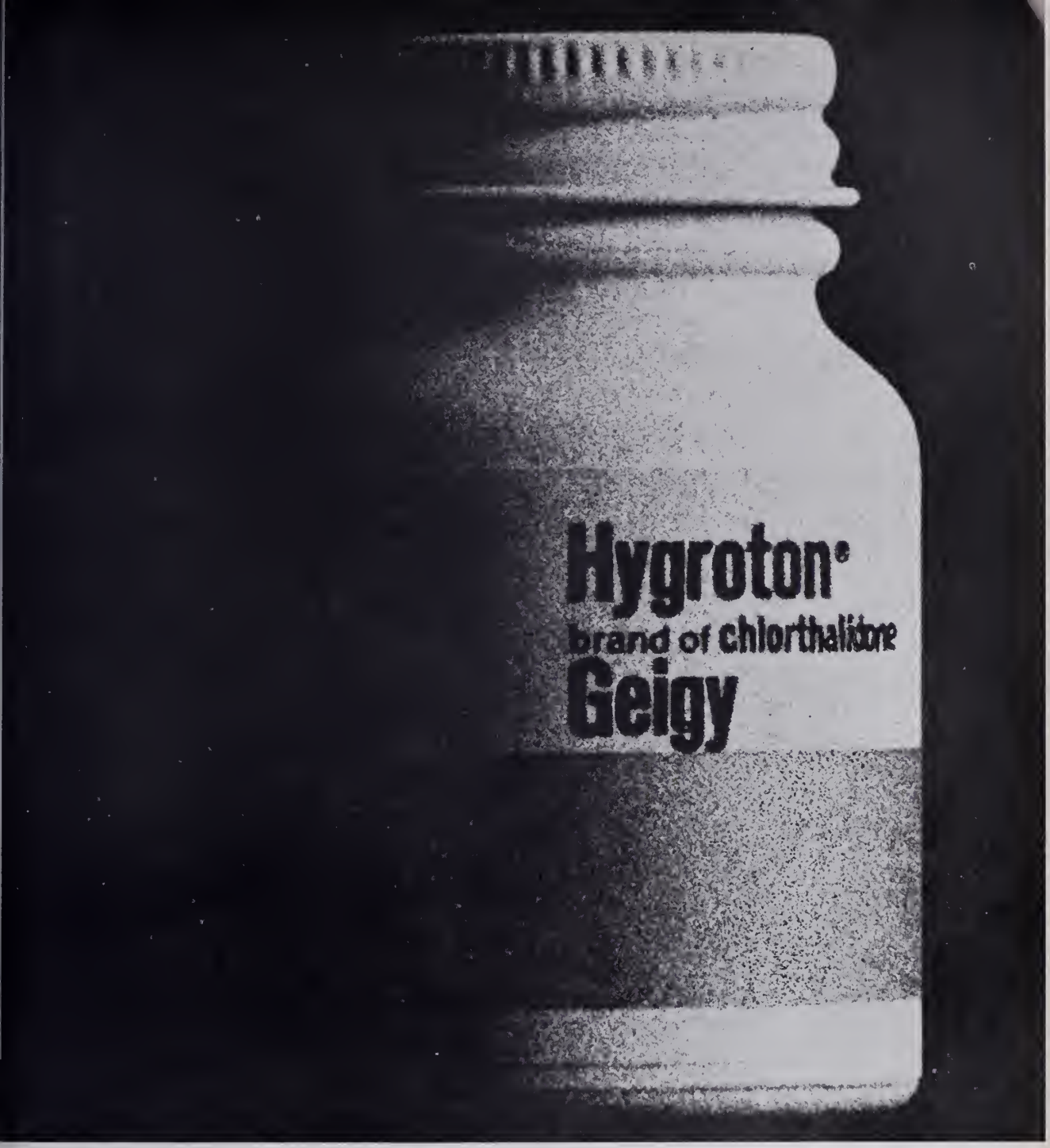

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Those resistant to other therapy.
And those intolerant of other diuretics.
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stitute. He will work under Dr. Michael DeBakey at the Texas Medical Center in Houston.

Dr. Balistreri Joins MU Staff

Dr. Frank Balistreri recently was appointed a clinical instructor in the Department of Physical Medicine and Rehabilitation at Marquette University School of Medicine, Milwaukee. Doctor Balistreri is chief of the physical medicine department at St. Michael's hospital, Milwaukee.

Dr. Kory Project Leader

Dr. Ross Kory, professor of clinical research, Marquette University School of Medicine, Milwaukee, and chief of the cardiopulmonary laboratory at Veterans Administration Hospital, Wood, is leader of a research project being conducted at the VA Hospital. Goal of the project, which is supported by the Wisconsin Heart Association, is development of a simple clinical screening test to detect heart and lung diseases.

Dr. Onkst at MU

Dr. Harold R. Onkst, Brookfield, is one of the recent appointees at Marquette University School of Medicine, Milwaukee. He is now an associate professor of anesthesiology at the School. Doctor Onkst, who received his M.D. from Ohio State in 1954, was with the University of Kansas Medical Center from 1962–1964.

Drs. Bolger, Nachazel Aid Project

As the result of work recently completed by the Waukesha Lions Club, *Dr. James V. Bolger*, Waukesha ophthalmologist, his associate, *Dr. Delbert P. Nachazel, Jr.*, and Waukesha Memorial Hospital, Waukesha is now a collection center for eye donors, linking it with the Milwaukee eyebank. The hospital is the collection center for persons who have authorized removal of their eyes after death, to be used in transplant surgery or for research. Medical control of the project rests in Milwaukee, with Doctor Bolger serving as local adviser for the collection center.

Dr. Peterson Retiring

Dr. M. G. Peterson, who came to Lake Mills "just to help out" back in 1925, retired from general practice in March after his intended short stay stretched out into nearly 40 years. He will, however, continue eye examinations.

It was a cousin, *Dr. G. E. Eck*, who inspired Doctor Peterson's interest in medicine and, later, invited him to help out as a Lake Mills general practitioner. Their association extended over a period of 14 years, ending in 1942. Since 1947, Doctor Peterson has been associated with *Dr. E. J. Netzow*. The two have been practicing in a modern clinic they built seven years ago.

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Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

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REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF FEB. 26, 1965

NEW MEMBERS

William Allen, 1011 3rd Street South, Wisconsin Rapids.
Harold E. Booker, 1954 East Washington Avenue, Madison.
James D. Curran, 8700 West Wisconsin Avenue, Milwaukee.
Theodore C. Feierabend, 2036 Sherman Avenue, Madison.
Kishin Gandhi, 630 South Central Avenue, Marshfield.
Warren J. Holtey, 630 South Central Avenue, Marshfield.
John T. McLaughlin, 620 Gerald Avenue, Sun Prairie.
Charles H. Miller, III, 765 West Washington Avenue, Madison.
Gustave C. Mueller, 2 West Gorham Street, Madison.
Frank L. Myers, 1300 University Avenue, Madison.
Jack H. Petajan, 1954 East Washington Street, Madison.
Mark J. Popp, 1565 A. White Drive, Rantoul, Ill.
Robert L. Sellers, 2209 East 5th Street, Superior.
Stephen E. Silvis, 630 South Central Avenue, Marshfield.

REINSTATED

Keith D. Epperson, 2320 North Lake Drive, Milwaukee.

CHANGES OF ADDRESS

Albert L. Babbitz, 4906 North Elkhart, Milwaukee 53217.
Edward F. Barta, Milwaukee, to 8823 West Jackson Park Boulevard, Wauwatosa.
Michael Barton, Oconto, to P.O. Box 1124, Dillon, Mont.
D. W. Betlach, 2520 Linden, Janesville.
E. H. Betlach, 2520 Linden, Janesville.
L. P. Brillman, 2031 Riverside Drive, Beloit 53511.
R. O. Brunkhorst, 5325 West Burleigh Street, Milwaukee 53210.
Richard J. Bukosky, Linden, N. J., to 11816 West Bluemound Road, Wauwatosa.
Sheldon L. Burchman, 250 West Bergen Court, Milwaukee.
Dayton D. Burkholder, Menomonie, to East Main Clinic, Anoka, Minn.
Alfons Busza, Milwaukee, to 825 Kurtis Drive, Elm Grove.
John P. Canavan, 735 Congress Street, Neenah.
H. W. Christensen, 502 3rd Street, Wausau 54401.
Donald P. Davis, 324 East Wisconsin Avenue, Milwaukee 53202.
Elsa B. Edelman, Milwaukee, to 400 Veteran Avenue, Apt. 314, Los Angeles, Calif. 90024.
Paul J. Fitzpatrick, Security, Colo., to 517 Yucca Drive, Colorado Springs, Colo. 80906.
Laurence L. Garner, P.O. Box 1608, Milwaukee.
Calvin J. Gillespie, Antigo, to 3237 South 16th Street, Milwaukee.
Anthony C. Hahn, 401 5th Street, Watertown.
Margaret E. Hatfield, 2210–60th Street, Kenosha 53140.
Jack D. Heiden, 110 East Main Street, Madison.
John D. Hurley, 2320 North Lake Drive, Milwaukee.
John H. Huston, Milwaukee, to 7927 Warren Avenue, Wauwatosa 13.
Kenneth M. Klatt, Baltimore, Md., to University Hospitals, Madison 6.
Richard A. Lende, Denver, Colo., to Albany Medical Center, Albany, N. Y. 12209.
Robert F. Lipo, Milwaukee, to 3227 South 145th Street, New Berlin.
Joseph A. Manago, 2320 North Lake Drive, Milwaukee.
Simon Matus, St. Louis, Mo., to VA Hospital, 333 East Huron Street, Chicago, Ill. 60611.
M. G. Peterman, 2000 South Eads Street, Arlington, Va.
C. L. Qualls, 112 East Maple Avenue, Beaver Dam.
Mac C. Roller, Plainfield, Ind., to 400 River Road, Lafayette, Ind. 47906.
Daniel G. Santer, 6439 North Santa Monica Boulevard, Milwaukee.
C. A. Sholtes, Richland Center, to 1208 Charles Street, Fort Atkinson.
Theodore Squier, 2619 East Wood Place, Milwaukee.
Albert H. Stahmer, 404 South 3rd Avenue, Wausau 54401.
Nicholas P. Staves, Milwaukee, to 6754 West Beloit Road, West Allis.
Estil Y. Strawn, 2218 North 3rd Street, Milwaukee.
Thomas F. Way, 652 West 20th Street, Merced, Calif.
J. F. Wyman, 316 East Calumet Road, Milwaukee 53217.
William N. Young, 5810 South 41st Street, Milwaukee 53221.

REMOVED FROM MEMBERSHIP

Kurt A. Hoehne, Dane County, removed per county secretary.
Donald E. Jacobi, Milwaukee County, resigned.
Marvin M. Kirchner, Milwaukee County, resigned.
Edward A. Liske, Jr., Dane County, transferred to Texas.
Joanna R. Miller, Kenosha County, resigned.

DEATHS

Erwin L. Rice, Milwaukee County, Jan. 7, 1965.
Edwin H. Federman, Columbia–Marquette-Adams County, Jan. 10, 1965.
J. P. McMahon, Milwaukee County, Jan. 23, 1965.
W. G. Meier, Jr., Sheboygan County, Jan. 28, 1965.
Samuel Rosenthal, Milwaukee County, Feb. 6, 1965.
Leo W. Peterson, Dane County, Feb. 9, 1965.
Ernst A. Pohle, Dane County, Feb. 10, 1965.
George E. Forkin, Winnebago County, Feb. 13, 1965.

CORRECTION!

Names of two members of the Society were inadvertently omitted from the membership roster which appeared in the January Blue Book issue. They are: Burton C. Dyson, M.D., Wausau, and Ernest F. Wallner, Jr., M.D., Milwaukee.

1965 **Wisconsin**

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 10–12: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 13: Annual Mount Sinai Hospital May Day program, starting at 9 a.m., Hospital Auditorium, 948 N. 12th St., Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

May 20: Postgraduate Program, Jackson Clinic, Madison.

June 4–6: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

Apr. 26–29: American Academy of Pediatrics, spring session, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 26–29: 36th Annual Scientific Meeting, Aerospace Medical Association, New York City.

Apr. 26–29: 14th Hahnemann Symposium, sponsored by Department of Medicine, Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia.

Apr. 26–30: American College of Physicians Postgraduate Course No. 13, Humphreys Postgraduate Center, Denison Auditorium, Denver.

Apr. 28–May 1: 9th Postgraduate course in Trauma, Chicago Committee on Trauma of American College of Surgeons, Chicago, Ill.

April 28 and May 26: 2nd and 3rd lectures of Spring 1965 Lecture Series of North Shore Hospital, 225 Sheridan Rd., Winnetka, Ill. Meetings start at 8 p.m. at hospital.

May 1–2: Seminar on Chronic Obstructive Lung Disease, Medical College of Georgia, Augusta, Ga.

May 10–14: ACP Course No. 14, Institute of Physical Medicine and Rehabilitation, New York.

May 14–15: Fifth Institute on Preventive Psychiatry, sponsored by University of Iowa Preventive Psychiatry Committee, University of Iowa, Iowa City.

May 14–16: 12th Western Cardiac Conference, on "Treatment of Cardiovascular Disease," Broadmoor Hotel, Colorado Springs, Colo.

May 21–23: Tri-State meeting of Illinois, Iowa, and Wisconsin Associations of Blood Banks, Davenport, Ia.

May 24–26: ACP Course No. 15, Royal Victoria Hospital on campus of McGill University, Montreal, Que., Can.

May 25: 5th International Thyroid Conference, Rome, Italy.

May 30–June 3: Medical Library Association Annual Meeting, Philadelphia, Pa.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 7–11: ACP Course No. 16, University of Iowa, Iowa City.

June 8–11: Catholic Hospital Association of United States and Canada, golden jubilee convention, Kiel Auditorium, St. Louis, Mo.

June 9–11: American College of Physicians Postgraduate Course No. 17, New York University Medical Center, New York, N. Y.

June 14–16: University of Colorado School of Medicine, religion and medicine conference, Estes Park, Colo.

June 14–17: American Proctologic Society, 64th annual meeting, Minneapolis, Minn.

June 16: Scientific Session of American Cancer Society, Philadelphia, Pa.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: Woman's Auxiliary to American Medical Association, 42nd annual convention, Americana Hotel, New York City.

June 20–24: American Medical Association, Section on Radiology, New York City.

MEDICAL MEETINGS

POSTGRADUATE COURSES

June 20–24: American Medical Association, 114th annual convention, New York Coliseum, New York.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

July 26–30: Continuation course on cardiac arrhythmias, Hahnemann Medical College and Hospital, Philadelphia.

July 29: 2nd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology, Vienna, Austria.

Aug. 2–6: Department of Pediatrics and Office of Postgraduate Medical Education of University of Colorado School of Medicine, 8th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 8: 8th International Anatomical Congress, Wiesbaden, Germany.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30–Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15, 1965–June 15, 1966: Tutorial program in cardiology offered by Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 13–14: American Heart Association Council on Arteriosclerosis, annual meeting, Hotel Deauville, Bal Harbour, Fla.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Oct. 28–30: American College of Gastroenterology, annual course in postgraduate gastroenterology, Americana Hotel, Bal Harbour, Fla.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30–Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–4: Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI meeting, Pick–Congress Hotel, Chicago, Ill.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

1965

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Mount Sinai May Day Program

Under the chairmanship of Dr. Robert A. Frisch, the annual Mount Sinai Hospital May Day program will be held in the Hospital Auditorium at Milwaukee Thursday, May 13, at 9 a.m.

The following papers will be presented: Hereditary Telangectasia, Dr. G. Guten; Giant Insulin Producing Islet Tumors of the Pancreas, Drs. R. W. Mann, E. C. Saltzstein; Pulmonary Embolectomy, Drs. A. H. Pemberton, Benjamin Narodick; Organ Scanning with Radioactive Isotopes, Drs. L. K. Mark, Morris Moel; The Vaginal Cytogram, Drs. J. J. Baron, M. F. Gutglass; Contraceptive Devices-Lippes Loop, Dr. J. A. Larkey; Immunologic Techniques Used in the Diagnosis of Systemic Lupus Erythematosus, Dr. G. C. Bernhard; The Elective Induction of Labor in Multiparas, Drs. Carl Levinson, E. A. R. Lord, Jr.

Guest speaker will be Dr. Robert F. Schilling, chairman, Department of Medicine, University of Wisconsin Medical School, Madison.

North Shore Lecture Series

The Spring 1965 Lecture Series of North Shore Hospital, sponsored by Lakeside Laboratories, Inc., opened March 31 at the hospital, 225 Sheridan Road, Winnetka, Ill., with a program on "Differential Diagnosis of Depression" presented by the hospital's medical director, Dr. Milton A. Dushkin.

The second lecture in the series is slated for April 28 at the hospital, on the subject, "Office Management of Emotional Problems in Adolescents," by Dr. Marvin Schwarz, formerly chief of child psychiatry, Presbyterian–St. Luke's Hospital, Chicago.

The final lecture will be presented May 26 by Dr. Beverly Mead, chairman, Department of Psychiatry, Creighton University, Omaha, Neb., on the topic, "Office and Home Management of Psychiatric Emergencies."

All members of the medical profession are invited to attend these lectures free of charge. Meetings start at 8 p.m.

ACP Postgraduate Courses

The American College of Physicians Postgraduate Course No. 17, "The Hemodynamic Basis for Auscultation," will be presented June 9–11 at New York University Medical Center, New York, N. Y. It will deal with the mechanism of the production of sounds and murmurs and their relation to the hemodynamic occurrences in the heart. Emphasis will be placed on the use of tape recordings and the simultaneous audio and visual presentation of these sounds.

Course No. 19, "Hematology for Internists, in the Light of Recent Developments," is slated for June 14–18 at University of Rochester Medical Center, Rochester, N. Y.

The course will consider primarily the clinical implications of research findings in fundamental biology and hematology, as they have developed over the past 10 years. Developments in the fields of genetics, cytogenetics, molecular biology, cell physiology, and biochemistry will be interpreted in the light of their significance for the understanding of pathogenesis, clinical manifestations, and treatment of hematological disorders.

Registration forms and requests for information should be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Woman's Auxiliary Convention

Achievement awards for outstanding community service projects, a luncheon honoring leaders of national women's voluntary organizations, and an address by Harold Russell, chairman of the President's Committee for Employment of the Handicapped, will be features of the 42nd annual convention of the Woman's Auxiliary to the American Medical Association, June 20–24 in New York. Reports emphasizing the Auxiliary's community service activities in disaster preparedness, health career recruitment, mental health, international health, safety and rural health will also be given to nearly 2,000 physicians' wives attending the meeting, which coincides with the AMA annual convention. Headquarters will be the Americana Hotel.

All members, their guests, and guests of physicians attending the AMA annual convention are invited to participate in the general sessions and social functions. A special program is planned for teenagers.

International Theme for AMA Convention

The 114th annual convention of the American Medical Association June 20–24 in New York City will have an international theme throughout the scientific programs.

"In keeping with the New York World's Fair, already drawing many thousands of foreign tourists to the city, the AMA has scheduled eminent foreign physicians to deliver lectures at the scientific meetings to be held during the convention," states Dr. J. Arnold Bargen, chairman of the AMA's Council on Postgraduate Programs which directs planning of the scientific sessions.

In addition to program participants, large delegations of physicians from many foreign nations will attend the convention and participate in the scientific sessions. Large groups from Japan, Mexico,

and many other nations already have indicated that they will attend.

"American physicians will have an opportunity at the New York convention to meet and mingle with other physicians from throughout the world, and to learn of current medical knowledge in other lands," said Doctor Bargen.

Hahnemann Continuation Course

"Interpretation and Therapy of Cardiac Arrhythmias" is the subject of the continuation course for internists, cardiologists, medical and cardiology residents July 26–30 at Hahnemann Medical College and Hospital, Philadelphia.

Topics to be considered include clinical significance of cardiac arrhythmias, electrophysiologic properties of impulse formation and conduction, premature systoles, nodal rhythms (nodal and ventricular escapes), refractory period of A-V node, A-V nodal conduction, A-V dissociation, reciprocal rhythms, mechanisms of depression of cardiac pacemakers, A-V block, SA block, exit block, paroxysmal and nonparoxysmal tachycardia, differential diagnosis of supraventricular and ventricular tachycardia, preexcitation, electrical alternans, Adams–Stokes, group beating and bigeminy, digitalis induced arrhythmias, and therapy of serious cardiac arrhythmias.

Tutorial Program in Cardiology

A nine-month tutorial program in cardiology will be offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif., Sept. 15, 1965, to June 15, 1966. This intensive program will cover the field of cardiovascular diseases and is especially designed for the physician in private practice who wants an academic year of organized instruction with freedom from direct patient responsibility. For details, write: E. Grey Dimond, M.D., Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

AHA Arteriosclerosis Council

The annual meeting of the American Heart Association's Council on Arteriosclerosis will be held October 13–14 in the Hotel Deauville, Bal Harbour, Fla., immediately preceding the AHA annual scientific sessions.

Abstracts of papers to be presented at the independent two-day Council meeting must be received before May 15. Official application forms for submitting abstracts, not to exceed 250 words, may be obtained from Douglas M. Smith, American Heart Assn., 44 E. 23rd St., New York, N. Y., 10010.

Council sessions will be open to all interested individuals.

Session on Stroke

A one-day scientific session on stroke will be featured in the program of the American Heart Association's 1965 sessions October 15–17 at the Americana Hotel, Bal Harbour, Fla. It is slated for October 16, with neurologists, neuropathologists, and neurosurgeons invited to submit abstracts of papers for the session. Emphasis will be on presentation of original investigative work in the cerebrovascular field.

May 15 is the deadline for receipt of abstracts, which should be based on original investigations related to cerebrovascular disease. Forms for submitting abstracts may be obtained from Richard E. Hurley, M.D., American Heart Assn., 44 E. 23rd St., New York, N. Y. 10010.

1965 ANNUAL MEETING

State Medical Society of Wisconsin

May 4–6, Milwaukee

Scientific Program

TUESDAY, MAY 4

10:00 Internal Medicine and Radiology, Milwaukee Auditorium

12:30 Scientific luncheons, Hotel Schroeder

2:00 Internal Medicine, Obstetrics and Gynecology, Pathology, and Radiology, Milwaukee Auditorium

8:00 Fireside conferences, Hotel Schroeder

WEDNESDAY, MAY 5

10:00 General Practice and Dermatology–Pediatric "Wet Clinic," Hotel Schroeder

12:30 Scientific luncheons, Hotel Schroeder

2:00 Dermatology, Orthopedic and Plastic Surgery, and Pediatrics, Milwaukee Auditorium

THURSDAY, MAY 6

10:00 Resident Competitive Papers, Milwaukee Auditorium

10:00 Otology, Milwaukee Auditorium

12:30 Scientific luncheons, Hotel Schroeder

2:00 Anesthesiology, Ophthalmology, and Surgery, Milwaukee Auditorium

Special Features

MEDICAL ART SALON sponsored by the Woman's Auxiliary to the State Medical Society, Milwaukee Auditorium

PHOTOGRAPHY EXHIBIT sponsored by the State Medical Society, Milwaukee Auditorium

COMPLETE PROGRAM IN MARCH ISSUE

WOMAN'S AUXILIARY

1965 Annual Convention—Program Highlights

MRS. F. H. WOLF
President-Elect

MRS. J. J. SATORY
President

MRS. W. H. EVANS
National President

Tuesday, May 4

3:00—REGISTRATION

East Mezzanine, Hotel Pfister

5:30—POUR LES "COCKTAILS" Honoring State Officers, Directors and Chairmen

North End of Cafe Rouge

6:30—BOARD OF DIRECTORS' DINNER AND MEETING Honoring Past State Presidents

Cafe Rouge, Hotel Pfister

Mrs. J. J. Satory, President, presiding

Those who attend: State Officers, Directors and Chairmen, County Presidents and Presidents-Elect, Past State Presidents, Past National President, and Honored Guests

Wednesday, May 5

8:30–12:00—REGISTRATION

East Corridor, Seventh Floor, Hotel Pfister

8:30–9:30—CONTINENTAL BREAKFAST

Empire Room, Seventh Floor, Hotel Pfister

9:30—FIRST BUSINESS SESSION

East Room, Seventh Floor, Hotel Pfister

12:30—LUNCHEON Honoring County Auxiliary Presidents

Milano Room, Milwaukee Athletic Club

"The American Dilemma"

Dr. Nicholas Nyaradi, Director
School of International Studies
Bradley University, Peoria, Illinois

(Guest Privileges)

MEETING OF COUNTY AUXILIARY PRESIDENTS AND PRESIDENTS-ELECT with Mrs. William Evans, Youngstown, Ohio, President, Woman's Auxiliary to the American Medical Association

Milano Room, Milwaukee Athletic Club

3:00–5:00—REGISTRATION

East Corridor, Seventh Floor, Hotel Pfister

6:30—RECEPTION OF THE PRESIDENT OF THE STATE MEDICAL SOCIETY OF WISCONSIN

East Room, Hotel Schroeder

7:15—ANNUAL DINNER OF THE STATE MEDICAL SOCIETY

Crystal Ballroom, Hotel Schroeder

Thursday, May 6

8:30—REGISTRATION

East Corridor, Seventh Floor, Hotel Pfister

8:30–9:30—CONTINENTAL BREAKFAST

Empire Room, Seventh Floor, Hotel Pfister

9:30—SECOND BUSINESS SESSION

East Room, Seventh Floor, Hotel Pfister

MEMORIAL SERVICE

Address by Mrs. William H. Evans, National President

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

1:00—LUNCHEON Honoring Mrs. William H. Evans, National President

Top of the Hilton Inn

"The Tired Mother Syndrome"

Leonard Lovshin, M.D.
Head of the Department of Internal Medicine
Cleveland Clinic, Cleveland, Ohio

(Guest Privileges)

POST-CONVENTION BOARD MEETING

MEDICAL MEETINGS *continued*

ACOG District VI Meetings

The schedule for 1965 district meetings and conferences on obstetric-gynecologic and neonatal nursing has been completed by The American College of Obstetricians and Gynecologists.

The meetings of District VI are scheduled for October 28–30 at the Kahler Hotel, Rochester, Minn., and November 10–13 at the Pick–Congress Hotel, Chicago, Ill. Advance registration will open approximately two months prior to the meetings which are open to all interested physicians, and the nursing conferences may be attended by all nurses who wish to advance their education in the specialty.

Annual Otolaryngologic Assembly

The annual otolaryngologic assembly will be held October 30 through November 5 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the University of Illinois College of Medicine offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Dr. Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested physicians should direct communications to: Dept. of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, P. O. Box 6998, Chicago, Ill. 60680.

SMA Section on Otolaryngology

The Section on Otolaryngology of the Southern Medical Association, which will have its annual meeting in Houston, Tex., November 1–4, announces that the guest lecturer will be Dr. Fletcher W. Woodward, emeritus professor of otolaryngology of the University of Virginia. Planned is a two-hour closed circuit color television program entitled "Repeat Tympanoplasty Procedures."

Deadline for reception of abstracts of papers for presentation at the meeting by the program committee is May 30.

Correspondence should be addressed to the Secretary: Neil Callahan, M.D., 500 Rodman Ave., Portsmouth, Va. 23707.

Western Cardiac Conference

Under the sponsorship of the Colorado Heart Association, the 12th Western Cardiac Conference will be held May 14 through 16 at the Broadmoor Hotel in Colorado Springs. Subject will be "Treatment of Cardiovascular Disease." For further information, write: Colorado Heart Assn., 1375 Delaware St., Denver, Colo. 80204.

Postgraduate Gastroenterology

The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Americana Hotel, Bal Harbour, Fla., October 28–30.

Subject matter will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. In addition to the several papers to be presented, there will be a clinical session at the Mount Sinai Hospital.

For further information and enrollment, write: American College of Gastroenterology, 33 W. 60th St. New York, N. Y. 10023.

A PERSONAL INVITATION from the AUXILIARY PRESIDENT

I should like to extend a personal invitation to each doctor's wife, widow, daughter, or sister to attend the 37th annual convention of the Woman's Auxiliary to the State Medical Society of Wisconsin, May 4–6. She need not be a member to attend our meetings or luncheons. Her acquaintance and company is desired.

We should like her to know what is being done by the Auxiliary in support of the medical profession. Having headquarters at Hotel Pfister this year is a new venture. Our general sessions will be held there May 5 and 6, from 9 in the morning until noon. She may come for all or part of the meetings. Advance reservations are necessary for the luncheons.

The May 5th luncheon at the Athletic Club will give the rare opportunity to hear internationally known Dr. Nicholas Nyaradi speak on "The American Dilemma." In a lighter vein, we are again fortunate to be able to present Dr. Leonard Lovshin, head of the Department of Internal Medicine of the Cleveland Clinic, Ohio. He will show slides and speak on "The Tired Mother Syndrome" at the May 6th luncheon. This will be preceded by cocktails around the roof garden pool at the top of the Hilton. Those who have heard either speaker comment, "You're in for a treat!"

Our national president, Mrs. William Evans, of Youngstown, Ohio, will be with us as will Mrs. Lovshin who is originally from Wisconsin.

Reports from counties indicate they too have a treat for us in reports.

If all of this does not intrigue, I must add that there will be excellent door prizes at the Wednesday and Thursday morning sessions. Again, I wish to extend a cordial welcome to the convention in May in Milwaukee.

Sincerely,

/s/ NINA SATORY, *President*
(Mrs. John Satory)

Signemycin® Bibliography

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Topical Treatment of Nose and Throat Carriers of *Staphylococcus Aureus* with Methicillin

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■ ALTHOUGH THE extent to which nose and throat carriers of *Staphylococcus aureus* may be held responsible for frank infections is a debatable point, there is general agreement that a reduction in numbers of staphylococci in the environment—particularly in hospitals—is desirable. (For a review discussion of this subject see Williams.[1]) It follows, therefore, that any safe way by which the numbers of organisms released by carriers (into the atmosphere and onto bedding, clothing, dressings, and the like) can be reduced would also be desirable, and it is assumed that clearing the carriers of their organisms, if feasible, would be the most effective way of preventing such dissemination.

An effort in this direction constitutes the subject of this paper. The work was stimulated by a report of Martin and Sword,[2] that *S. aureus* exposed to sublethal concentrations of methicillin (dimethoxyphenyl penicillin) became sensitive to lysozyme. It is known that lysozyme exists abundantly in nasal secretions and in appreciable amounts in saliva (Fleming[3]), and it was rationalized that for this reason methicillin might be effective, when topically applied, to a greater extent than other antibiotics which do not have the property of rendering the organisms sensitive to lysozyme. In addition there is the consideration that virtually all staphylococci have been shown to be sensitive to the action of methicillin (Simon[4] and Jevons, Coe and Parker[5]). Still further considerations are that sensitization of subjects by small amounts of a topically applied antibiotic seems less likely than by large amounts of an agent administered systemically; and that resistance of the organisms to this antibiotic has not easily developed to date (Stewart[6]).

Methicillin as an agent to reduce numbers of staphylococci among carriers has already been tried by others with considerable success, but under conditions somewhat different from those adopted by us. Whereas we have employed a nebulized spray directly into the nose and mouth, Varga and White[7] used an ointment in the anterior nares and Elek and Fleming[8] and Goldfarb and James[9] sprayed the antibiotic into the atmosphere in proximity to patients in surgical wards. Our study also differs from others by including throat cultures in addition to nose cultures.

Among the other agents which have been investigated previously for the treatment of carriers, only hexachlorophene, as a powder for dusting (Simpson, Tozer and Gillespie[10] and Tulloch, Alder and Gillespie[11]);

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framycetin, a British antibiotic, (Stratford et al[12] and Porter et al[13]) as an ointment or nasal spray; neomycin as a nasal cream (Tulloch, Alder and Gillespie[11]), and erythromycin—route not stated—(White[14]) have been moderately successful.

Subjects. Subjects were chosen for inclusion in the study on the basis of two consecutive cultures yielding *Staphylococcus aureus* (coagulase positive) from the nasal or oral pharnyx or both. All were adult medical technology students or employees of the laboratory or of the maternity nursing service of this hospital. A total of 29 persons were treated. Four were men; 25 were women. Six had had consistently positive cultures at intervals over a period of several years; the remainder had not had cultures taken until one month before the nebulizing treatment.

Three carriers with a history of hypersensitivity to penicillin were not included in the study. This was to avoid, as far as possible, any chance of accident, for it has been demonstrated that allergy to penicillin often carries with it allergy to methicillin. Parenthetically it may be noted, however, that the topical administration of methicillin by others to large, unselected groups has had no untoward effects.

The ears, nose and throat of all but 3 of our subjects were examined during the course of the study. No significant abnormalities were found except in one woman who had bilateral chronic otitis media. *Staphylococcus aureus* was subsequently grown in culture from her ears.

Contrary to the findings of Jacobs, Williamson, and Willis,[15] we found no correlation between tonsillar abnormality, or indeed presence, and the carriage of staphylococci in the throat.

Cultures. Cultures were grown on Staphylococcus Medium ‡110 (Difco) and were identified by the coagulase reaction in reconstituted rabbit plasma (Difco "Coagulase Plasma"). Calcium alginate swabs (Higgins[16]) were used through both nostrils to reach the nasopharynx, and in the throat just behind the uvula. Care was taken to rotate the swab in inoculating the plates. Numbers of staphylococci were estimated only roughly. Contrary to White[17] we feel that more careful counts usually have little significance inasmuch as numbers of organisms may vary considerably from time to time. (For example, one of our subjects over a period of four months prior to treatment sometimes yielded only 1 or 2 colonies per swab, whereas at other times she yielded confluent growth.) A rough rating of: Few (fewer than 15 colonies); 1+ (15 to 50 colonies); 2+ (50 colonies to closely spaced colonies); and 3+ (closely spaced to confluent growth) was made.

Phage sensitivity studies were not done.

Treatment and Results. The apparatus used for treatment was a De Vilbis ‡640 nebulizer with nose and mouth attachments, with an intermittent positive pressure pump as source of energy. Three days to one week before the antibiotic was administered each subject was given a preliminary inhalation of the diluent alone for the same time interval and by the same route or routes as were to be used with the drug. This served a threefold purpose. (a) It permitted instruction of the subject in the use of the apparatus. (b) It served as a control for the actual treatment, allowing each subject to be his own control of the effects of the diluent without the drug. (c) Since cultures were always taken within 24 hours after this control inhalation, the status of the Staphylococcus population immediately prior to treatment could be ascertained.

This final culture just before treatment in addition to the one taken one month previously to locate the carriers, enabled us to use a period of one month prior to treatment for comparison with one month after treatment to judge the overall effect of the treatment in altering the location of the organisms, as reported in Table 1. One student lost her organisms after the control inhalation. After being given an interval of several weeks to regain them, she lost them again following the inhalation of the diluent alone. She was, of course, dropped from the experiment and was not treated with methicillin.

We tried three ways of treating with the methicillin. At first, in the nature of a pilot study with only 9 subjects, one treatment consisting of 20 mg of Staphcillin in 1.0 ml of physiological saline was administered by inhalation via the nasal route. The apparatus was so adjusted that, with normal breathing, most subjects took about six minutes to inhale the entire amount. Cultures were taken 24 hours after treatment and weekly thereafter until positive again for staphylococci,

or weekly for four weeks if negative, and monthly thereafter. Results are given in the first two columns of Table 2 and show 3 subjects not cleared by the treatment (organisms persisting particularly in the throat). Of the 6 who were seemingly cleared, 3 regained *S. aureus* within one week, 1 within two weeks, 1 within three weeks and 1 not until more than four months later.

Inasmuch as the organisms could be demonstrated in these subjects so soon after treatment—3 of them not being rid of them at all—a second trial was run one and a half months later with two consecutive daily inhalations of the same amount of the drug in the same volume as the single dose given the first time. This modification was suggested by the results of Varga and White[7] who administered ointment over a long period and of Goldfarb and James[9] who used daily atmospheric spraying over a long period. Six of the original subjects who had regained staphylococci or had kept them, plus an additional one, served in this trial. Every one of them showed staphylococci in his throat after the second inhalation, except the one individual who had staphylococci only in his nose just before the treatment. That one lost his organisms through the double treatment, but regained them again two weeks later. When they reappeared, they came first into the throat alone, and a week later were present in both nose and throat.

Since immediately after the double treatment staphylococci were found only in the throat, the treatment was modified to include inhalation *via* the mouth for part of the time, the total amount of Staphcillin was increased to 30 mg for each of the two days, and 0.01% lysozyme was included in an effort to augment the natural supply of the throat, which is known to be lower than that of the nose (Fleming[3]). Also, Ringer's solution instead of normal saline was used as the diluent in an attempt to make the environment as nearly normal as possible. Inhalation was *via* the nose for three minutes, with the remainder of the solution being inhaled through the mouth with the mouth attachment. Seven of the original subjects after a stabilizing interval of two months and a new control inhalation of Ringer's solution were included in this trial and 19 new subjects were added—a total of 26 for this part of the study. Again in 4 persons the throat failed to clear. One of these was the otitis media patient mentioned in the paragraph concerning the medical examination of the subjects, but there was no explanation for the failure of clearing in the others.

The organisms remaining in these throats were fully sensitive to 1 microgram per milli-

TABLE 1—*Change in Status of Subjects One Month Following Last Methicillin Treatment as Compared With One Month Previous to First Treatment*

	Extent of Colonization		
	Unchanged	Spread (from nose to nose and throat or from throat to nose)	Improved (loss of staphylococci completely or change to throat occurrence only from previous nasal occurrence)
Spontaneous	14	11	4
After Treatment	13	3	13

TABLE 2—*Overall Results of Three Methods of Treatment*

	Single inhalation 20 mg nasal route		Two consecutive days inhalation 20 mg each day—nasal route		Two consecutive days 30 mg each day. 3 min. nose—remainder mouth		Overall results on total of 29 subjects	
	Before treatment	Two months after treatment	Before treatment	Two months after treatment	Before treatment	Two months after treatment	Number at beginning	Number after end
Positive nose and throat	7	2	4	4	17	9	11*	9
Positive nose only	1	1	1	1	3	4	13	5
Positive throat only	1	3	2	2	6†	9	5	10
Completely negative	0	1	0	0	0	4	0	5

*Four of these participated in all three of the series of treatments; 2 never cleared, 1 cleared for two weeks with one treatment but failed to clear with two, 1 cleared for two weeks with both kinds of two-day treatment, but not with one alone.

†One of these was positive in the nose only prior to the first treatment.

NOTE: The figures apply to numbers of subjects only and do not imply any particular subject. For example, the subject positive in the nose only after the first treatment is not the same person who was positive in the nose only before treatment.

liter of methicillin as determined by tube test in trypticase-soy broth. Of those who were cleared, 6 subjects regained the organisms within a week (5 in the throat and 1 in the nose), an additional 8 within two weeks, 3 more in three weeks, another one at four weeks, but 4 remained free of staphylococci for two months, which is as long as they were followed. These 4 in addition to the one who remained free for a long time after the single, initial treatment make a total of 17% who remained clear in both nose and throat for a significant length of time.

Using the criterion accepted by other workers for success in treating the carrier condition, namely absence of staphylococci from the nose, the percentage of favorable results rises to 50, which is in line with previous work. This result is not significantly skewed toward success by the fact that persons who were solely throat carriers were included among the 29 subjects, since there were only 5 of these and 3 were in the unchanged column (Table 1) at the end of the experiment.

Since changes in the status of a carrier condition are known to occur spontaneously without any intentional treatment, the occurrence of such spontaneous change in our 29 subjects during the month previous to their first methicillin treatment is compared with the results in the month following their final treatment. This comparison appears in Table 1. It should be emphasized that this table reports the month-long effects only, and that if shorter term improvements had been included the figures would have been much more impressive. Even after a month's interval the effect of the drug is evident in the comparison of the figures before and after treatment in the second two columns.

Whereas without treatment the organisms tended to spread from the nose to include the throat or to invade the nasal region from the throat, after treatment a significantly large number of carriers had lost their organisms or had them confined to the throat. The throat is generally considered a less significant source of dissemination than the nose. (See Williams[1] for discussion.)

Sensitivity Studies. Upon first reappearance of staphylococci in any subject following treatment the culture was tested for sensitivity to methicillin by the agar diffusion method with 5-microgram paper disks. All cultures were sensitive. In addition cultures obtained from individuals who could not be cleared by the inhalation treatment were tested by the tube method. Cultures taken both before and after treatment were included, and at both times the organisms were as sensitive to methicillin as were those from other subjects. All were sensitive to 1 or 2 micrograms per milliliter of the antibiotic.

Discussion. There is nothing in the results of this study to encourage alteration of the prevalent opinion that the treatment of nasopharyngeal carriers to try to rid them of staphylococci is of little value. Although 50 per cent of our subjects were reduced from nasal carriers to throat carriers or lost their organisms completely for a period of two months, there is no guaranty that these individuals also would not, in time, regain the organisms. In fact one, completely negative for two months after treatment, was followed longer than the others because she was one of the original subjects. She showed confluent growth from her throat in the culture taken at the fifth month, and these organisms had spread, to some extent, to her nose by the end of the sixth month. It is our feeling that the gains demonstrated by somewhat reduced numbers in the total carrier reservoir do not outbalance the hazards of developing strains of staphylococci resistant to this drug (Stewart and Holt,[18] Jevons, Parker and Coe[4]) which at present has such singular usefulness in therapy of frank infections.

We feel that the most useful outcome of this survey is the evidence that throat carriers are potentially nasal carriers. On seven occasions—most notably the individual cited in the previous paragraph who became recolonized after five months—recolonization in persons originally nasal carriers occurred first in the throat and some time later spread to the nose. This was demonstrated also in a few instances by the cultures taken prior to treatment. We believe, therefore, that even if it is true (and we are not entirely convinced) that persons who are harboring staphylococci only in the throat are not significant sources of dissemination in a hospital environment, they should nonetheless be included in carrier surveys. They may be one explanation of the frequency of "sporadic carriers"—not really sporadic at all.

In the course of the culturing we did in this study, involving some persons not ap-

pearing in the tables as subjects, we found only 2 truly sporadic carriers in the sense that they yielded no staphylococci from either throat or nose on some occasions (although they had not been treated) but did have them at other times. We have no evidence that all persons acquire staphylococci (perhaps only briefly) some time or other in the nasopharynx if they are completely free of them most of the time. Monthly cultures over some years on some of the personnel in the maternity nursing service have failed to reveal a positive culture in many of those individuals.

Another observation which is probably worth reporting is that upper respiratory infections were consistently accompanied by reduced numbers of staphylococci and sometimes by reduction in the extent of colonization.

And finally, with as careful attention to standardization of technique as we could manage, we failed to establish any consistency in the approximate numbers of organisms from time to time in most individuals prior to treatment; and we feel therefore that counts, or even rough estimations of numbers such as ours have been, are not significant in long-term evaluations of the disseminating potential of any individual carrier. The most critical evaluation of dispersal by carriers which we have found (Noble[19]) does not mention numbers of organisms, but states rather that the individuals most responsible need not be consistent carriers.

Summary. Treatment of 26 carriers of staphylococci on two successive days with a nebulizing spray containing 30 mg of Staphcillin inhaled partly through the nose and partly through the mouth resulted in eradication of staphylococci from the nasopharynx of 50 per cent of the subjects for a period of two months thereafter. However, some of these still had staphylococci in the oral pharynx.

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The Secretory Effects of Gastric Freezing on the Dog's Stomach

A Comparison with Various Published Surgical Procedures

By WILLIAM A. KISKEN, M.D., JOHN T. HARRINGTON, JR., B.S., and JOSEPH W. GALE, M.D., F.A.C.S., Madison, Wisconsin

■ SINCE THE introduction of gastric freezing in 1962 by Dr. Owen H. Wangensteen[1-3] and his group, much has been written concerning its therapeutic efficacy in the treatment of duodenal ulcer. Some of this writing has appeared in the lay press and consequently we have received many inquiries regarding "gastric freezing." In an attempt to acquaint ourselves with the procedure, we undertook a program in the surgical laboratory where we studied the technique of gastric freezing and the effect of gastric freezing on hydrochloric acid secretion in the dog's stomach.

Methods. Twenty-four adult mongrel dogs weighing between 15 and 20 kg were utilized. Under general anesthesia a Stamm gastrostomy was placed in the antral portion of the stomach close to the pylorus. The serosal surface of the stomach was sutured to the anterior abdominal wall, and the tube was brought out through a stab wound. (The apparatus is shown in Figure 1.) Seven to ten days after the gastrostomy procedure, the dogs were positioned without premedication in Pavlov stands. One hour unstimulated secretions were then collected from the gastrostomy tube. The dogs were then given 0.2 mg of histamine (base) subcutaneously and secretions were collected during the second hour. The dogs were then placed back in their cages. Frequently, additional prefreeze studies of stimulated and unstimulated gastric secretions were obtained. After the control studies were completed, each dog was lightly anesthetized and its stomach was "frozen" for 50 minutes with a –15 C. outflow temperature. Either the Swenko or the Shampaine hypothermia machine was used in freezing. After the balloon was passed into the stomach, it was distended with 600 to 725 ml of coolant. One hour to two days following the freezing, basal and histamine stimulated gastric secretions were repeated.

Six animals were explored at the time of freezing to ascertain the position of the balloon. (These dogs were sacrificed and not used for secretion studies.) Five dogs died during freezing, due to total body temperature drop. Large dogs showed less total body temperature drop, but they were more difficult to handle in the Pavlov stand. Thirteen dogs completed the entire study.

Sodium pentobarbital anesthesia was used initially, but was later abandoned and sodium methohexital and succinyl-choline chloride were used to induce light anesthesia. Positive pressure respiration was used in all dogs during the freezing procedure.

Results and Discussion. In the 13 dogs that completed the study, we noted a 12.4% decrease in the basal hydrochloric acid secretion and a 17.4% decrease in the histamine stimulated hydrochloric acid secretion after

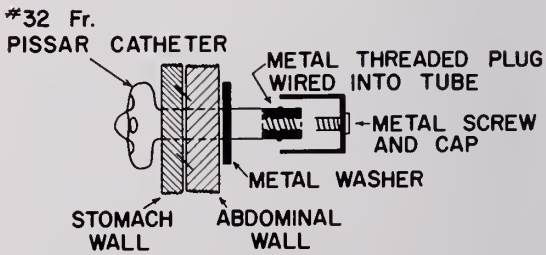

Fig. 1—Mechonicol drawing of the apparatus used to keep the gastrostomy tubes securely in place.

From the University of Wisconsin Medical School. Doctor Kisken is an Instructor, Department of Surgery. Mr. Harrington is at present a Senior Medical Student. Salary support was received from a general research support grant to the University of Wisconsin Medical School from the National Institutes of Health, Division of Research Facilities and Resources, Bethesda, Md. Doctor Gale is Professor of Surgery.

TABLE 1—*Effect of Various Procedures Upon the Acidity and Volume of Secretions in the Dog's Stomach*

	Basal (Meq. HCl.)	Histamine (Meq. HCl.)	Volume
Vagotomy alone[7,8]	77%	Not Reported	56%
50% Gastric Resection[6]	89%	70%	Not Reported
50% Gastric Resection and Vagotomy[6]	93%	81%	Not Reported
80% Gastric Resection[5]	85%	95%	Not Reported
Author's Study Gastric Freezing	12.4%	17.4%	9.8% (basal)

gastric freezing. Although the decrease in the secretion of hydrochloric was definite, it was not of the magnitude that was expected. Therefore, a search of the literature was made to find out how various surgical procedures affect the hydrochloric acid secretion in the dog's stomach. Table 1 compares the results. Upon comparing our data with published data, gastric freezing on the whole stomach falls far below vagotomy, 50% gastric resection, 50% gastric resection and vagotomy, and 80% gastric resection, in producing decreases in the basal and histamine stimulated secretions of hydrochloric acid. Volume studies are published only with vagotomy alone; a 56% decrease was noted, compared to a 9.8% in our studies with gastric freezing.

When the dogs were explored at the time of freezing, it was found that the balloon was never in contact with the antrum, and consequently this area was not frozen. The posterior stomach surface was involved to the greatest degree in the freezing. Dogs with and without gastrostomies revealed a similar pattern of freezing. We postulate that the high degree of freezing of the posterior stomach cooled both the aorta and the vena cava and caused the precipitous drop in body temperature seen in the smaller dogs.

Summary. Preparation of a dog, utilizing the whole stomach for freezing, is described. Results of basal and histamine stimulated gastric secretion before and after gastric freezing are presented. Comparison of gastric freezing with various surgical procedures is made.

Conclusion. To effect a decrease in hydrochloric acid production, gastric freezing of the dog's stomach falls far below the published results of vagotomy, 80% gastric resection, and 50% gastric resection with and without vagotomy. Gastric freezing of the dog's stomach causes less volume decrease than vagotomy. Gastric freezing is an experimental procedure and needs careful reevaluation.

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CARDIOLOGIST RELATES METHODS HE USES TO DISSUADE PATIENTS FROM SMOKING

The methods he uses in efforts to discourage his patients from cigarette smoking are related in an article by the noted Boston cardiologist, Howard B. Sprague, M.D., which the American Heart Association has reprinted for distribution to physicians.

The article, "What I Tell My Patients About Smoking," first appeared in the October, 1964 issue of the Heart Association's publication, *Modern Concepts of Cardiovascular Disease.* In addition to suggesting various ways to dissuade patients from smoking, Doctor Sprague lists "behavior categories" of habitual smokers which many other physicians will doubtlessly find familiar.

Copies of the article may be obtained free of charge from local Heart Associations or the American Heart Association.

The Specter Ventricular Fibrillation

By GEORGE G. ROWE, M.D.
Madison, Wisconsin

■ DURING THE COURSE of his physiology lectures at Wisconsin Dr. J. A. E. Eyster customarily demonstrated certain of the classical experiments utilizing an open chest dog. On one occasion when the animal was brought into the auditorium, ventricular fibrillation occurred unexpectedly, early in the experiment. Assuming at once that his intended demonstration was not possible, and faced by an unexpended period with a room full of students, Doctor Eyster retrieved what grace he could by altering the protocol and discussing ventricular fibrillation. He had scarcely made the point that if it persisted more than a few seconds ventricular fibrillation was uniformly fatal when organized ventricular contraction took over, and the preparation was again ready for use. Such an event is not easily forgotten, but at the time, on the best of authority, was categorized as rare.[1] Indeed Wiggers recorded that spontaneous defibrillation of a dog's ventricles had occurred only once in 400 instances which he had observed in the laboratory.[2]

The tendency toward recovery from ventricular fibrillation is known to vary among species. Thus Hooker considered experiments conducted on ventricular fibrillation in cats as unsatisfactory because of their "tendency to spontaneous recovery."[1] Gradually it became apparent that spontaneous defibrillation might also occur in man and the clinical suspicion arose that transient ventricular fibrillation was among the mechanisms for the development of Stokes–Adams syncope. Many of the instances observed early were considered possibly due to artefacts produced by muscle potentials or transient loosening of the electrocardiograph connections during the convulsions and consternation, which accompany such an attack. Eventually, however, good electrocardiographic documentation of transient ventricular fibrillation appeared and it was established that in man, too, this life-threatening arrhythmia was occasionally temporary and interrupted itself spontaneously with recovery from a syncopal episode.[3, 4]

Prevost and Batelli's demonstration of electrical[5] and D'Halluin's report of chemical defibrillation of the ventricles in the dog[6] established the principle of deliberate defibrillation. Wiggers made the practical point that cardiac massage could be utilized to maintain the circulation until ventricular fibrillation was interrupted electrically so that experimental animals need no longer be lost because of this arrhythmia.[7] Beck was quick to apply this knowledge to man,[8] and open chest therapeutic electrical defibrillation with successful resuscitation was born.[9] With the advent and popularization of closed chest cardiac massage in man[10] a new phase of interest in cardiac arrest ensued for it became possible to sustain life with a marginal, but apparently adequate cardiac output during prolonged ventricular fibrillation without exposing the heart. Under these circumstances every cardiac death became potentially reversible since physical and emotional preparation for thoracotomy were no longer required. Indeed in some circles ventricular fibrillation was discussed as a transient physiologic state to be induced under special circumstances to facilitate radiographic demonstration of the coronary vessels.

Meanwhile, during cardiac surgery, it became apparent that difficult intracardiac procedures could be done more readily if the heart were quiet, and if splashing blood did not interefere with vision. Since grave concern arose that anoxic or hyperkalemic cardiac arrest might produce permanent injury to the myocardium, it was reasoned that if ventricular fibrillation were induced, organized cardiac contraction would be avoided and a relatively quiet, dry surgical field could be secured without these risks. It was known that if the heart were cooled excessively, ventricular fibrillation was a common event, particularly during cardiac manipulation,[11] and therefore it became the custom of some cardiac surgeons to lower the cardiac temperature to the point where the surgical procedure induced fibrillation. Some hearts, however, remain resistant to fibrillation at levels of body temperature which the surgeon preferred to use and consequently ven-

From the Cardiovascular Research Laboratory, Department of Medicine, University of Wisconsin Medical School.

tricular fibrillation was initiated by application of transient electrical discharges to the myocardium.[12]

With sustained cardiac perfusion from the cardiopulmonary bypass apparatus, however, there is a distinct tendency for the heart to recover from fibrillation spontaneously. Indeed with more prolonged experience spontaneous recovery of organized contraction has become sufficiently troublesome that an electrical device has been manufactured for applying an alternating current continuously to the myocardium in order to induce and sustain ventricular fibrillation.* When the intracardiac procedure has been accomplished, and quiescence is no longer required, the current from the fibrillator is interrupted, and frequently during the suturing and warming of the myocardium, ventricular fibrillation disappears spontaneously with return of sinus rhythm. If spontaneous defibrillation does not occur by the time normal temperatures are reached, the heart is ordinarily easily defibrillated electrically. However, sometimes with the application of countershock, defibrillation is achieved in only a portion of the heart. When this occurs the fibrillatory process may be observed to proceed gradually over the cardiac surface from one atrium or ventricle to the other taking over that portion of the heart which has an organized beat and reverting to fibrillation.

The process of fibrillation does not appear to cross from the atrium to the ventricle, hence the atria may continue to fibrillate after the ventricles resume normal contraction, and under these circumstances atrial fibrillation may persist indefinitely. It is sometimes possible by a carefully placed electrical shock to defibrillate the atria without disturbing the rhythm of the ventricle. If ventricular fibrillation is induced by the transatrial discharge, a defibrillating current may be reapplied to the heart as a whole.

Ventricular fibrillation during cardiac catheterization is ordinarily regarded with alarm, and past experience has shown that this is usually justified. However if closed chest massage is instituted without delay, ventricular fibrillation may revert to sinus rhythm promptly, even without application of countershock. Subsequent discussion with the patient may reveal no knowledge of the episode other than for transient rapid cardiac action, presumably the ventricular premature contractions which immediately precede fibrillation. Even if ensuing events include electrical defibrillation through the chest wall this may not be recalled.

Recently in our laboratory two episodes of ventricular fibrillation occurred in the same individual during catheterization of the pulmonary artery. The patient's recovery from through-chest massage was so prompt on each occasion that the diagnostic procedure was completed with determination of cardiac output, transseptal catheterization of the left atrium and ventricle, retrograde catheterization of the left ventricle through the aorta, and left ventriculography. The required information was obtained by completion of the study, and the patient had no recollection of any untoward occurrence even though he was alert mentally and his general condition the same throughout the rest of the day as it had been prior to the catheterization.

In recapitulation, it may be stated that although ventricular fibrillation carries the risk of death, there are now many documented instances in which it has subsided without treatment or has been interrupted by prompt effective therapy. Those experienced in cardiac catheterization regard ventricular fibrillation with considerable respect but no longer with the same terror it once induced. It would not have seemed likely in 1940 when Wiggers reviewed this fatal arrhythmia that the specter ventricular fibrillation would ever be harnessed and put to clinical use. The cardiac surgeon has done this on a day to day basis regularly enough to justify purchase of special apparatus which will maintain fibrillation as long as he desires. Thus, although familiarity may breed contempt, in some circumstances it may also breed mutual respect and cooperation.

* Medtronic A. C. Fibrillator.

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NEW DRUGS AND NEW TREATMENT

Differential Diagnosis. Surgical and non-surgical jaundice can be differentiated with a high degree of accuracy by a recently developed method employing I^{131}-labeled rose bengal. Through scintillation counting external to the body, the technique permits simultaneous determination of biliary tract patency and quantitation of liver damage. It provides about twice the accuracy of simultaneous liver function tests.

Biliary function is determined by noting whether or not the test solution enters the intestine after the administration of cholecystokinin. Absence of a gallbladder does not prevent flow of dye into the liver. Any rise in the abdominal activity count indicates a patent biliary tract.

Liver function is determined by the rate of disappearance of radioactivity from the blood. Blood retention, which is the activity count 20 minutes following injection expressed as a percentage of the count 5 minutes after injection, is 50 per cent or less in normals.

Tumor Tests. A new diagnostic test for pheochromocytoma has been developed at the National Heart Institute. The technique is based on a rise in blood pressure produced by the injection of tyramine. After preliminary conditioning, 250 micrograms are injected. If the rise in blood pressure is less than 20 mm Hg, 500 micrograms are injected; if the rise is still negligible or inconclusive, 1,000 micrograms are injected. A rise in excess of 20 mm Hg following any of these injections suggests pheochromocytoma; the diagnosis is confirmed by urinary catecholamine determinations. The rise in blood pressure following the injection of tyramine in patients with pheochromocytomas is thought to be due to the ability of the drug to release noradrenalin from tissue storage sites; these are probably "overstocked" in patients with pheochromocytoma.—Reprinted from *International Medical Digest*, 80: 394 (Oct) 1964.

PLANS FOR ARTHRITIS CLINIC AT UNIVERSITY HOSPITALS ANNOUNCED

Plans to reactivate the arthritis clinic at University Hospitals beginning July 1, 1965, and medical committee appointments were announced in March by George T. Rayne, chairman of the Arthritis Foundation's Dane County Action Committee. The group met March 12, at the Madison Club.

Mr. Rayne read a letter to the Arthritis Foundation written by *Dr. Robert F. Schilling*, professor and chairman of the department of medicine at the University of Wisconsin Medical School, which reported the school's intention to reactivate the clinic. Mr. Rayne said the Arthritis Foundation would do everything it could to support the program, particularly a request to underwrite a postdoctoral research fellowship which is included in the school's plans.

The amount of funds necessary to underwrite the fellowship will be determined within the next two months. In 1959 the Arthritis Foundation allocated $10,000 to the medical school for arthritis research.

Dr. D. Murray Angevine, professor of pathology at the University of Wisconsin Medical School, accepted the appointment as chairman of the Arthritis Foundation's Dane County medical committee. Doctor Angevine is also on the board of directors of the Foundation's state chapter.

Also serving on the Dane County medical committee are: *Drs. Robert M. Becker* and *Walter R. Sundstrom*, both internists; *Jack D. Heiden* and *Kenneth M. Sachtjen*, both orthopedist surgeons; *Robert A. Siebert* and *Arthur A. Siebens*, both physical medicine specialists.

Noting the plans for the University Hospitals arthritis clinic, Mr. Rayne pointed out that in January 1965, one of the announced objectives of the Arthritis Foundation in Dane County would be to seek renewed interest in the rheumatic diseases at the University.

"Doctor Schilling's letter reporting the clinic plans is certainly concrete evidence of the medical school's interest and we are most pleased by it," Mr. Rayne said.

Other local objectives of the Arthritis Foundation will be to open a year around information and referral bureau which would serve the Madison metropolitan area, and to sponsor patient education courses on arthritis for victims of the disease and their families.

Mr. Rayne said the Arthritis Foundation would need a minimum of $12,000 to carry out these objectives. A May fund campaign would seek that amount, he said.

Based on United States Public Health Service surveys, in Dane county there are 16,000 persons who have arthritis in some form. It is the leading cause of chronic, crippling illness.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: Charles I. Bowerman, M.D.
Marshfield, Wisconsin

Case Presentation.* The patient, a 42-year-old white man employed as a garage mechanic, was admitted to the hospital for the first time on Apr. 8, 1962, and was discharged three days later. His chief complaint on this occasion was "pain in the right lower chest when breathing." There was no associated shortness of breath. He had run a low-grade fever for a week prior to admission and had been treated at home with an antibiotic. He stated that he had been ill in January 1962 for two weeks with an undiagnosed febrile disease, but had no respiratory symptoms at that time. He described a 15-pound weight loss. There had been no hemoptysis.

On physical examination the patient was well developed and well nourished and not acutely ill. Blood pressure was 130/68 mm Hg, pulse rate was 80 and regular, and temperature 99.6 F. There was a slight decrease in breath sounds at the right base posteriorly. No rales were present. The heart was not remarkable. The left ankle jerk was absent.

The diagnostic impression at this time was pleurisy with effusion, and a consultant recommended bronchoscopy and bronchographic studies. The bronchoscopist described "crowding of all right lower lobe bronchi" as the only abnormality. The chest x-ray film on admission showed extensive "pleural change" in the chest on the right with a small amount of free fluid (Fig 1). A somewhat ovoid area of increased density in the midlung region superimposed on the minor fissure was also visible. Papanicolaou smears of the bronchial washings were negative. Cold agglutinins were negative. Cultures of the bronchial washings were negative for fungi and acid fast organisms. Hemoglobin was 13.2 gm/100 ml and white blood cell count (WBC) 6,600 per cu mm with a normal differential. The urinalysis, blood urea nitrogen (BUN), and blood sugar were all normal.

The patient was given no medication and was dismissed improved with a diagnosis of resolving pneumonia and pleurisy, right lower lobe. Skin tests for blastomycosis, coccidioidomycosis, histoplasmosis, and tuberculosis (intermediate strength) were negative.

He was readmitted in December 1962, complaining of pain in the chest anteriorly on the left side of 36 hours duration, associated with deep breathing. This was preceded by a 10-day history of left superficial thrombophlebitis which had been treated with phenylbutazone (Butazolidin).

On physical examination there was dullness with decreased breath sounds over the left base posterolaterally. His blood pressure

Fig. 1—In April 1962, a chest x-ray film showed infiltrate superimposed on segment of right lower lobe.

* From St. Joseph's Hospital.

Fig. 2—In December 1962, a chest x-ray film showed clearing of the infiltrate in right lung and a new infiltrate in the left base.

Fig. 3—In February 1963, clearing of the two previous infiltrates and development of a new infiltrate in the right upper lobe are shown.

was 160/90 mm Hg, pulse 80, respirations 20, and temperature 98.6 F. There were no murmurs. There was only minimal tender thickening over the left midanteromedial thigh. Skin tests on this occasion were repeated and his histoplasmin skin test was quite strongly positive.

The history was then elicited that he had been working with dove droppings. A chest x-ray film showed blunting of the left costophrenic angle, associated with pneumonia or pleuritis in this area (Fig 2). His hemoglobin was 13 gm/100 ml, WBC 8,800 per cu mm, sedimentation rate was 85 mm per hour, no lupus erythematosus (LE) cells were seen on one examination and his RA test was negative. Antistreptolysin "O" titer was 166 Todd units. Two blood cultures showed no growth.

The patient again was not treated with antibiotics and was dismissed with a diagnosis of pneumonia and pleuritis involving the left lower lobe, etiology not determined, and a subsiding superficial thrombophlebitis, left thigh.

The patient was readmitted Feb. 21, 1963, complaining of pain and swelling of the left calf of two days duration.

On physical examination he appeared acutely ill. His temperature was 100 F., pulse was 100 and regular, respirations were 22. Chest was clear. Heart was not remarkable. There was swelling, tenderness, and pitting edema of the left leg, especially the calf with prominent superficial veins. Homan's sign was positive. A chest x-ray film showed an infiltrative lesion involving the right upper lobe (Fig 3). Intravenous pyelograms and cholecystogram were normal. An upper gastrointestinal (GI) series disclosed an active duodenal ulcer. Barium enema was negative.

Laboratory studies included a hemoglobin of 12 gm/100 ml and WBC 10,700 cu mm. Four LE preparations were negative. Sedimentation rate was 80 mm per hour. Fasting blood sugar was 132 and BUN 17 mg/100 ml. Serum bilirubin, serum glutamic oxaloacetic transaminase (SGOT), cholesterol, were within normal limits. Blood uric acid was 4.6 mg/100 ml, total serum protein 7.4 gm/100 ml (albumin 3 and globulin 4.4). There were no cryoglobulins.

The patient was treated originally with anticoagulants because of his thrombophle-

bitis, but he developed gastrointestinal bleeding and the anticoagulants were discontinued. His hemoglobin fell to 9.2 gm/100 ml. Electrocardiographic (EKG) studies on admission showed a sinus tachycardia with a right axis deviation with inversion of the T waves in lead V1, V2, and V4. Serial cardiograms were procured and the cardiologist felt that these changes were not sufficient to make a diagnosis of pulmonary embolus or pericarditis. A diagnostic pulmonary biopsy was carried out on Mar. 6, 1963.

Clinical Discussion. *Dr. Gerald R. Marschke:* This is the case of a 42-year-old man who developed a febrile illness for two weeks in January 1962. This was probably the beginning of his difficulties, but I believe the symptoms were too vague for a definite diagnosis to be made at the time. Four months later, he entered the hospital because of fever and chest pain. The physical and x-ray findings were those of a right pleural effusion. He was well investigated, but most studies were negative, including skin tests for major fungi and tuberculosis. It might be of some importance to note that the fasting blood sugar and blood pressure were normal at this time.

The left ankle jerk was absent and I would like to dwell on this for a minute. We have no other evidence of any disease of the nervous system. Although an absent ankle jerk may be an unrelated characteristic of this patient, I think many of us have seen people with a non-neurologic injury or disease in one extremity, which somehow interferes with relaxation and prevents obtaining a deep tendon reflex.

The patient apparently got along fairly well until eight months later, in December 1962, when he had a 10-day episode of left superficial thrombophlebitis which was treated with phenylbutazone. Thirty-six hours of pain in the left side of his chest, associated with deep breathing, apparently precipitated his admission. Physical findings and chest x-ray films showed pleural fluid and underlying disease at the base of the left lung. His temperature and pulse were both normal, but his blood pressure was higher than when he was seen previously. Now his histoplasmin skin test had become positive and information was obtained that he had been working with dove droppings. The major blood studies were normal, except for an elevated sedimentation rate. The complement fixation test for histoplasmosis was negative.

He was next hospitalized on Feb. 21, 1963, with signs and symptoms pertaining to his chest on the left. For the first time he was described as being acutely ill. There was thrombophlebitis of the left leg. His chest x-ray film showed an infiltrate involving the right upper lobe. X-ray studies of the GI, biliary, and rental systems were done, I think in search of a primary tumor, since there were no abdominal complaints. The only abnormality discovered was a duodenal ulcer. The patient was treated with anticoagulants before the ulcer was found and he promptly developed gastrointestinal bleeding. His bleeding came under control, presumably with discontinuance of the anticoagulants. An EKG study showed a sinus tachycardia, right axis deviation, and some T wave changes, and a lung biopsy made the diagnosis. I would like to have the EKG studies discussed now.

Dr. Fred W. Fletcher: The initial EKG revealed right axis deviation with T wave inversion in the right precordial leads. EKGs were taken March 14 and March 16. These revealed very minor and nonspecific ST segment and T wave changes. They were diffused in the standard and augmented limb leads, particularly leads 2, 3, and AVF. There were also diphasic T waves in the precordial leads V3 through V6. The tracing taken two days later showed some improvement. These were interpreted as nonspecific and the interpreter at this time doubted pericarditis or pulmonary emboli as had been suggested previously. Neither tracing at this time showed the classic S1-Q3 pattern of pulmonary emboli.

Doctor Marschke: Were these on the last admission?

Doctor Fletcher: March 14 and March 16, the final admission.

Dr. Robert E. Bodmer: This patient had multiple x-ray films made on three admissions. His initial film showed an area of infiltrate or haziness in the right lower lung field with a diaphragmatic pleural adhesion going up to it. The left lung field was clear. The cardiac silhouette was within normal limits.

On the lateral film the infiltrate could not be seen anteriorly, so I believe it was posterior. The lateral decubitus chest film showed a very minimal amount of fluid present on the right side and a bronchogram

showed good filling of the segments out into the infiltrate. The infiltrate was actually located in the superior segment and the bronchi were a little crowded together, but they went right through it. I thought that this ruled out a tumor.

On our last film on this admission, Apr. 11, 1962, the infiltrate was clearing just a bit and the diaphragmatic pleural adhesion had almost resolved. So the patient had a minimal effusion and a negative bronchogram for tumor. When he returned in December 1962, the right lower lobe infiltrate had cleared, except for a few fibrous residuals. Then he had an infiltrate in the left lung field, elevated diaphragm on that side, and pleural thickening. The decubitus chest film again showed a very minimal amount of fluid on the left side. So we had an infiltrate that had resolved on the right side and a new infiltrate on the left side.

His third admission was in February 1963 and on this admission the infiltrate which had been on the left side on the second admission had now almost entirely cleared. There were some fibrous streakings remaining. The costophrenic angle had been reestablished, although the diaphragm remained slightly elevated and he had a new infiltrate in the right upper lobe. We have a series of following films made on February 23, March 4, and March 20. On successive films this infiltrate started to clear somewhat and on the last film it had a radiolucent center, but at that time he had also had a pulmonary biopsy, so that this radiolucency might have been caused by the biopsy. On his last admission he also had pyelograms which were normal, upper GI series which showed a duodenal ulcer, normal colon, and normal gallbladder.

Doctor Marschke: Did you see any blood vessels leading up the right upper lobe mass?

Doctor Bodmer: I did not see any anemic lung. I saw fairly normal blood vessels going up to it.

Doctor Marschke: Was there any sort of a hilum?

Doctor Bodmer: No.

Doctor Marschke: On previous films, was there any hint of the right upper lobe infiltrate being present?

Doctor Bodmer: No, the right upper lobe was clear on both admissions. There were some heavy markings there, but no infiltrate.

Doctor Marschke: Viewing the x-ray films changes my opinion of this somewhat. I am going to go through with the discussion that I had planned; it could still be pertinent and perhaps for somebody it might be worth hearing, but I am going to reverse my field. I think that this man had more than one condition and I will proceed from the concrete to the less concrete to the purely speculative. I believe he had a duodenal ulcer because one was seen on the x-ray studies. In passing we might remember that phenylbutazone has activated duodenal ulcers, but I am not sure whether we should blame the ulcer on this drug, because a period of some two to three months elapsed between its administration and the discovery of the ulcer. I think that the patient's gastrointestinal bleeding after anticoagulation came from that ulcer.

On two occasions I think it was quite definite and on one occasion it was suggestive that there was thrombophlebitis in the left lower leg. On a couple of occasions, when evidence was very specific for thrombophlebitis, he had symptoms of acute respiratory distress supported by x-ray and physical findings. I think we would have to make a diagnosis of recurrent pulmonary emboli from thrombophlebitis of the left leg.

Febrile symptoms with a history of working with birds suggest three different conditions that may have occurred. I am indebted to Dr. Robert Heywood, because I did not previously know of it. He told me that there is an allergic syndrome associated with exposure to pigeon dander, droppings, or feathers which has been described by Dr. Charles E. Reed of the University of Wisconsin. It is of acute nature, coming on several hours after working with the birds, but I do not believe this patient's symptoms suggest an allergy.

The other two conditions are ornithosis and histoplasmosis. Only on his last admission was the patient described as acutely ill, but his symptoms did not very well fit the prostration, headache, hacking cough and the like that are described with ornithosis. Therefore I am inclined to eliminate that diagnosis. However, the histoplasmin skin test changed and I think that the patient, sometime in association with his illness, developed a primary infection with histoplasmosis.

Since the skin tests became positive sometime between April and December 1962, I assume that his primary infection occurred prior to that. I think that his very first epi-

sode, treated at home and consisting of a fever of unknown origin, may very well have been primary histoplasmosis.

I believe that the major problem with this man is the differential diagnosis of the involvement of the right upper lobe. I think we can rule out tuberculosis, because he had a skin test which was negative. Granted that negative skin tests occur in active tuberculosis, they usually occur in extremely ill patients who develop anergy, and I do not think this patient was that ill. Could it have been histoplasmosis? I think that the evidence is good that he had had this disease.

Following a primary infection with histoplasmosis, one of four things can happen. It can completely resolve; it can heal with evidence of calcification and fibrosis; it can disseminate; or it can form a fibrocavitary, chronic, active disease. I thought that the complement fixation titers might have been of value because the type of histoplasmosis that I considered would be the active fibrocavitary type. In this, however, the titer usually remains high several months after reinfection rather than dropping.

I also wondered if this could be a malignancy. We all realize that recurrent thrombophlebitis is sometimes a tip-off to a hidden malignancy. Such malignancies when identified are usually of the lung or pancreas. I specifically pointed out the hyperglycemia and hypertension because I was considering the possibility of a Cushing's syndrome associated with malignancy. The clinical picture of Cushing's syndrome under such circumstances is not too clear cut. Only about 50 per cent of the cases have the buffalo hump, striae, moon face, acne, and other features which would lead us immediately to think of Cushing's syndrome. The rest have only evidence of diabetes and hypertension.

The tumors which most often cause it are bronchogenic carcinoma, thymomas, and pancreatic malignancy. A half dozen other tumors can cause it with much lower frequency. However, I do not think that the evidence is very great for a malignancy. The lesion was biopsied and left in, and it appears to me that it could have been taken out. I have a strong feeling that this is not a malignancy. It could have been histoplasmosis, but it has a rather soft, transient appearance on x-ray films and I think I would favor another pulmonary embolus in his right lung. I have not completely ruled out a histoplasmosis granuloma or a malignancy, but I tend to favor an embolus with pulmonary infarction.

Fig. 4—Lung biopsy showed pulmonary infarction revealing necrotic lung tissue with marginal zone of fibrosis and organizing granulation tissue.

Dr. Charles I. Bowerman: The lung biopsy was performed on the right side with an incision at the fifth intercostal space. In this area the parietal pleura was found to be fused to the underlying lung and a wedge of lung was taken. A frozen section was performed and the diagnostic impression at the time was organizing infarct (Fig 4). The permanent sections corroborated this impression. The tissue sections showed that much of the tissue was composed of eosinophilic staining, necrotic lung parenchyma with preservation of the outline of many of the alveolar walls. Some of the alveolar spaces were filled with degenerating red cells and fibrin. The pleura was thickened and fibrotic, and extending into the subjacent lung from the pleural surface was a proliferation of fibroblasts which was producing organization. The basic lesion here was an infarct of the lung which showed moderately advanced organization.

Because of the continuing danger of recurrent embolization to the lung, the patient was taken to the operating room on March

11 for ligation of the inferior vena cava. Before this procedure, a closed thoracotomy on the right was carried out to insure against tension pneumothorax from positive pressure for anesthesia in the face of the recent lung biopsy. Only a minimum amount of air was encountered and no persistent leak was found. Following this the inferior vena cava was incised and several fragments of thombus material, measuring up to 2 cm in greatest diameter, were removed from this vessel. The inferior vena cava was doubly ligated and divided. There were no other noteworthy findings in the abdomen other than some adhesions in the region of the duodenum. Doctor Dovenbarger is currently following the patient and I would like to call upon him for further information and comments.

Dr. William V. Dovenbarger: An additional possibility we considered in the differential diagnosis at the time of his last admission was a vasculitis of some variety in view of the migratory pulmonary infiltrate which can be a feature of this. Following caval ligation the patient got along well. I have seen him on several occasions since that time and he is working actively. He wears supportive stockings and has no significant edema. He was able to work without dyspnea or chest pain. There was no recurrence of emboli and his x-ray films showed good clearing of the area in the right upper lobe. So here is a patient, I believe, that benefited greatly from this therapeutic procedure.

I should make a few comments about the pulmonary emboli in general. At Philadelphia General Hospital, it was found that 4 per cent of the deaths were due to pulmonary emboli. This is a significant figure and it is even higher than that in institutions with chronically ill patients. There are various series of autopsies determining the incidence of pulmonary emboli and I think in one series of 300 autopsies, 34 per cent of the patients had pulmonary emboli. Only 6 per cent were suspected prior to death and this is certainly a large diagnostic error. DeBakey has estimated as great as 50 per cent error in diagnosis. So this is a difficult disease to diagnose.

The suspicion should obviously be very high and I think that we must always keep it in mind, especially in postoperative patients and patients with cardiovascular disease. I suppose that in our experience anybody who has an unexplained infiltrate postoperatively which is not obviously pneumonia may well have pulmonary emboli until proven otherwise. In anyone with unexplained dyspnea, unexplained central nervous system symptoms, and in patients with heart failure who are worsening without an obvious cause, we have to consider the possibility of pulmonary emboli.

Why is this so hard to diagnose? Obviously the process rarely follows the textbook pattern of pulmonary emboli, such as pleuritis, thrombophlebitis, and friction rubs. I am sure that to those of us who have seen many of these now, this is the uncommon manifestation rather than the common. In the literature it is documented that these signs are very infrequent. I think the leg signs occur in an estimated 15 per cent of patients who have pulmonary emboli, hemoptysis occurs in about 10 per cent, and pleuritic pain in about 10 to 15 per cent. So we have to dismiss these things as being a real help in diagnosing this disorder.

The other ancillary studies are not of much value either. The EKG does not show much specific change until the patient is in real trouble. The pulmonary artery pressure does not rise and cause right heart strain and EKG changes until about a half to two-thirds of the pulmonary arterial tree is occluded. So it takes many emboli over a long period of time or else a massive embolus to do this. The other ancillary studies certainly are not that helpful either. So it is primarily a clinical suspicion and we have to think of it quite constantly in hospital practice.

I think we should talk briefly about the terms pulmonary infarction and pulmonary embolus. In the past we have always thought of these synonymously, but this association is not always present. Only about 10 per cent of emboli produce infarction although the reason for this is generally not too clear.

At the recent American College of Physicians meeting an excellent paper was presented reporting actual postmortem angiograms on patients who were found to have pulmonary emboli. It was found that without infarction there were definite collaterals between the pulmonary and bronchial circulation which developed both at the site of the embolus and also more distally. If the infarct involved the pleura there were collaterals between the rib cage systemic arteries and the pulmonary artery. These collaterals protect against infarction and this is undoubtedly the reason we do not see more pulmo-

nary infiltrates and definite evidence of infarction.

The problem of treatment in this condition is also difficult. Anticoagulants have been used on a long-term basis, but there are inherent dangers. This was manifested in this particular patient with a duodenal ulcer which bled when he was treated with anticoagulants. Caval ligation or venous interruption of some variety is recommended. The choice often arises between femoral and caval ligations. Many people have a very poor opinion of caval ligation because of such possible complications as edema and stasis ulcer.

In one study, made at Harvard, caval and femoral ligations were compared. It was felt that the incidence of postoperative morbidity was much higher in femoral ligation due to wound hematomas and hemorrhage from the slippage of ligatures, and that the procedure of choice was caval ligation. It was found that 10 per cent of patients developed significant dependent edema following this procedure which usually improved over a four to eight week period. The incidence of postligation embolus is much higher following femoral ligation because, unless the patient has definite leg signs below the inguinal area, one may not be dealing with leg vein thrombosis. So caval ligation is a good procedure and in such patients it should be performed.

A point for discussion is whether they should be given a trial of long-term anticoagulants. What would have happened to this man if this diagnosis had not been made? There were three definite possibilities. One, he could have gotten well, resolved his emboli gradually, and had no trouble at all. I think this is a very remote possibility. Two, he could have had massive embolus and death. Reviewing cases of massive emboli, two-fifths or more had evidence of preceding smaller emboli. I think this could have happened to this patient as well, considering the fact that at operation he was found to have a thrombus extending into the vena cava. The third possibility is that he would continue to have small emboli over a long period of time and gradually develop pulmonary hypertension and right heart failure.

This is exemplified by a middleaged man who presented with dyspnea and right heart failure and who, in fact, had massive embolization of the pulmonary arterial tree, thrombosis, organization, and died because of this. We feel the etiology was probably multiple embolization.

It is interesting to speculate whether this is really what we call idiopathic pulmonary hypertension. Some authorities do feel that the entity which we call idiopathic pulmonary hypertension is in reality organization of multiple pulmonary emboli and this is a point that has been repeatedly debated. It certainly can cause the same effect over the long run.

Dr. Richard D. Sautter: I would disagree on one point. I believe vena caval ligation is the operation of choice for the treatment of pulmonary embolism when the pulmonary embolism does not immediately threaten life. If the embolism immediately threatens life, then, of course, pulmonary embolectomy is indicated. I have recently operated upon a man with pulmonary thrombosis who developed symptoms over a period of three years. This is exactly the same picture that I would expect to have developed in the patient currently under discussion had not his cava been ligated. Femoral ligation, I believe, is a poor procedure compared to vena caval ligation for the simple reason that in caval ligation there are no subsequent pulmonary emboli.

A case must be really exceptional at this institution to avoid vena caval ligation after the proven diagnosis of pulmonary emboli. It is my feeling that the cava should be ligated with the first pulmonary embolism. This can be easily proven by pulmonary arteriography. I think the indication for anticoagulants is very limited and confined to those patients who have absolute contraindications to vena caval ligation. In the case under discussion, the diagnosis was made by lung biopsy. This procedure, which is easily accomplished, has very low morbidity and no mortality today, and has been performed by Dr. B. R. Lawton on nearly 100 patients. It should not really be discussed in the context of an operative procedure at all, but rather a diagnostic study. It saves the patient a great deal of time and expense by making a prompt diagnosis. This procedure should be done more often in the diagnosis of pulmonary disease.

Dr. Bahij S. Salibi: Why wasn't a pulmonary angiogram done on this man?

Doctor Sautter: Because the diagnosis had been confirmed by the pulmonary biopsy.

Doctor Salibi: But why wasn't the angiogram done before or instead of the pulmonary biopsy?

Doctor Sautter: Because at that time the diagnosis was not suspected. There were several other diagnoses under consideration.

Doctor Salibi: That is the point. The clinical signs and symptoms of pulmonary embolism can be misleading. Pulmonary angiography is a relatively safe procedure and should be done more often.

Doctor Sautter: Pulmonary embolectomy, of which we now have three successful cases, will be an even more infrequent operation if the diagnosis is more often suspected and made, because ligation of the vena cava will prevent pulmonary embolism of such magnitude as to necessitate pulmonary embolectomy. This man's disease is different from massive pulmonary embolism. He had repeated small showers of pulmonary emboli. The patient referred to previously, who had pulmonary thrombosis, had a history of two years of mildly increasing dyspnea. At the time we saw him he was cyanotic. His pulmonary artery pressure was 100 mm of mercury, and although he was successfully placed on the heart-lung machine and the majority of the thrombi removed from the main pulmonary arteries, he still succumbed on the table. While attempts were made to resuscitate his heart, I repeatedly measured his systemic and pulmonary artery pressure. His pulmonary artery pressure always exceeded his systemic by as much as 50 mm of mercury. At autopsy, random segments from all lobes of the lung showed that the small pulmonary arteries were nearly all completely blocked. Some were recanalized, but there were no normal pulmonary arteries or arterioles seen within these specimens.

Dr. George L. River: Has anyone done any follow-up work in the long-term morbidity associated with vena caval ligation?

Doctor Sautter: There are several reports in the literature which paint a rather dismal picture of people with caval ligations. This, however, has not been our experience, which was recently reviewed by Doctor Lawton. Of the patients in the past three years who have had vena caval ligation, none is incapacitated because of the caval ligation. Nearly all of them have some mild stasis edema, but none of them has the giant extremities described by some authors.

I remember several of the cases, two of which stand out in my mind. One was a 21-year-old woman who had a successful pulmonary embolectomy and caval ligation. She now works eight hours a day as a cosmetologist and spends most of the time on her feet. She has no real disability. The other is a nurse at this institution who, in addition to having her cava ligated had both ovarian veins ligated. She still works eight hours a day as a floor nurse. I would say for a life-saving procedure, this operation has a very slight morbidity.

Dr. Thomas G. Olsen: Pulmonary angiography is a very valuable procedure for establishing the diagnosis of pulmonary infarction or embolism. In the past 15 months we have performed 19 angiograms of which 18 were positive, giving a 95 per cent accuracy. The occluded arteries are demonstrated as well as the defects caused by clots in the main trunks.

The preferred method is to place a catheter in the main pulmonary artery under fluoroscopic control and obtain the film study. This insures a diagnostic study, even in the seriously ill patient. The procedure has been well tolerated in all cases, with no reactions or complications encountered.

LONG-TERM IMMUNITY TO TETANUS—A STATISTICAL EVALUATION AND ITS CLINICAL IMPLICATIONS

Gottlieb, Stanley, McLaughlin, F. X., Levine, Leo, Latham, W. C. *and* Edsall, Geoffrey—*American Journal of Public Health and the Nation's Health,* 54: 961 (Jun) 1964.

A group of 66 individuals who had gone 14 to 21 years since their last dose of tetanus toxoid was studied to determine the effect of a standard booster dose and to identify and evaluate factors which influenced the degree of response. All demonstrated a significant rise in titer two weeks following the booster dose. A series of mathematical models were formulated to describe the parameters influencing the prebooster and postbooster titers. By combining the data of several authors a theoretical distribution curve of prebooster titers was generated. This showed that once an individual has been immunized his circulating titer will never fall to zero.

Alum-precipitated toxoid was recommended as the agent of choice, and once an individual has been immunized it is unnecessary to repeat the series. In previously immunized individuals, tetanus antitoxin is unnecessary and a booster dose of toxoid at the time of injury provides adequate protection.

The authors believe that routine booster doses of toxoid need not be given more frequently than every 10 years except in the event of injury.—Reprinted from *International Medical Digest,* November 1964.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Enzymes as Therapeutic Agents

By JOSEPH J. BARBORIAK, Ph.D.
Milwaukee, Wisconsin

■ ALTHOUGH ENZYMES have been used therapeutically for a relatively long time, their application has been limited to only a few areas, such as supplementing the digestive enzymes or debridement of open wounds. More recently, improved techniques for isolation and purification of proteins and for standardizing enzyme activity has allowed introduction of new and more potent enzyme preparations. These may be divided into the following categories:

1. Most commercial products still consist of preparations supplementing or replacing the *native digestive enzymes*. The majority of them contain pancreatic extract with proteolytic, amylolytic, and lipolytic activities and are protected by enteric coating against gastric digestion. Some of the products also include the gastric protease pepsin and bile acids; still others contain cellulases—enzymes breaking down complex carbohydrates of the cellulose type. (Cellulases are usually of fungal origin; they are not produced by the human digestive system.)

The primary indications for therapy with digestive enzymes are exocrine pancreatic deficiency, such as pancreatitis or cystic fibrosis and surgery affecting the organs of the digestive system, such as cholecystectomy, resection of pancreas, gastrectomy, and others. Experimental proof of the *in vivo* efficacy of the digestive enzymes in man is limited mostly to those with lipolytic activity. Studies with I^{131}-tagged triolein suggest that certain lipase-containing enzyme preparations improve, to some extent, lipid absorption in patients with pancreatitis or gastrectomy.[1] Reduction of fecal fat content in gastrectomized patients receiving lipase preparations has also been reported.[2] The claims about effectiveness of digestive enzymes in reducing gastric discomfort, flatulence, belching, and nervous indigestion are based mostly on subjective reports and do not seem to be supported by sufficient clinical evidence.

2. Increasing numbers of *oral enzyme preparations* are being introduced as *systemic anti-inflammatory agents*. The enzymes offered for this purpose are: (a) *Chymotrypsin*, a pancreatic protease, used either alone or in combination with *trypsin*, which is also a pancreatic proteolytic enzyme. (b) *Bromelains*, which are a group of proteolytic enzymes isolated from the pineapple plant. They show a relatively broad proteolytic spectrum and digest fibrin, casein, hemoglobin, and other proteins. (c) *Papain* is a plant protease isolated from the fruit of the *Carica papaya* tree. Papain needs to be activated by sulfhydryl-reducing agents, such as cystein. (d) *Alpha-amylase* is a glycosidase usually present in human saliva and pancreatic juice which digests complex polysaccharides, such as amylose, glycogen, and dextrin. The enzyme used in some commercial preparations is of bacterial origin. (e) *Streptokinase-streptodornase* preparation; streptokinase, an enzyme isolated from streptococci, activates plasminogen to a physiologically proteolytic enzyme plasmin. No activity is claimed for orally administered streptodornase. In most preparations, the enzymes are protected by enteric coating against gastric digestion or are in the form of buccal tablets.

Opinions about the therapeutic benefits of oral enzyme preparations in inflammation or in injury to soft tissues are far from being unanimous. Doubts have been expressed as

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to whether the large enzyme molecules can pass unchanged through the intestinal mucosa in high enough concentration to produce sufficient enzyme activity in the circulation. The results of some animal studies indicate, however, that certain proteolytic enzymes, if used in high concentration, do cross the intestinal barrier[3] but whether this is due to an enzyme-induced change in mucosal permeability remains to be investigated. It is also argued that the proposed rationale for the therapeutic use of enzymes in inflammation, i.e. a removal of the fibrin occlusion in capillary vessels surrounding the injured area is in error and might, in fact, delay the healing process. Surveying the available laboratory and clinical evidence, the Council on Drugs of the American Medical Association has reported recently that, on the basis of the currently available information, the therapeutic usefulness of oral anti-inflammatory enzyme preparations is not established.[4]

Side effects after oral enzyme preparations are rare, and when they do occur they are usually not serious. However, caution is advised when anticoagulants and some of the broad spectrum proteolytic agents, such as papain or bromelain are administered simultaneously.

Trypsin and chymotrypsin are also available in injectable form for intramuscular injection with suggested uses in soft tissue injuries, and various surgical and ocular conditions. Both enzymes are antigenic and their repeated parenteral administration might lead to sensitization and to allergic and anaphylactic reactions.

3. *Enzyme* preparations used *topically* for *debridement* contain proteolytic enzymes such as trypsin, chymotrypsin, papain, or fibrinolysin; some contain desoxyribonucleases, to liquify purulent exudates, and antibiotics. These products are used for enzymatic debridement of burns, topical ulcers, wounds, postpartum cervical erosions, and the like.[5] Allergic reactions, although rare, can also occur with topical enzyme preparations.

4. *Fibrinolysin* or *plasmin* is a native proteolytic enzyme which dissolves fibrin clots. It is normally present in the circulation in an inactive form as plasminogen and can be activated to plasmin either by *streptokinase*, the above mentioned enzyme produced by streptococci, or by *urokinase*, an activator isolated from human urine. Both the plasmin and the kinases are available and are promoted for use in thrombophlebitis, pulmonary embolism and peripheral arterial thrombosis. It is currently believed that the kinases might be more suitable preparations for the thrombolytic therapy than the plasmin itself,[6, 7] since the doses of plasmin required to overcome the circulating plasmin inhibitors can also induce fibrinogenolysis and a serious clotting defect. Of the two kinases, only streptokinase is available in large quantities. However, its use is complicated by several factors, such as presence of inactivating antibodies in patients who have had either a streptococcal infection or previous streptokinase therapy, both of which make the patient resistant to the treatment; also most of the streptokinase preparations are pyrogenic. Urokinase is a human protein and therefore not antigenic. In addition, pure preparations do not seem to be pyrogenic. In comparison with streptokinase, urokinase is much less inhibited by circulating inhibitors. However, it is not yet widely available and at the present time, it is very expensive.

5. *Penicillinase* is a highly purified injectable enzyme obtained from cultures of *Bacillus cereus*. It is intended for treatment of allergic reactions to penicillin.[8] Penicillinase catalyzes the opening of the lactam ring in the penicillin molecule to produce penicilloic acid, which is not antigenic. However, penicillinase itself is an antigenic protein and its repeated administration might elicit allergic responses. The enzyme is not effective in hypersensitivity reactions provoked by the newer penicillinase-resistant types of penicillin.

6. *Hyaluronidase* is a glycosidic enzyme hydrolyzing hyaluronic acid, the "cement substance" of the connective tissue. It is used therapeutically to promote absorption of topically or intradermally applied drugs, in hypodermoclysis, and for removal of local edema.[9] It should not be used on infected tissue.

7. *Thrombin* is a protein catalyzing transformation of fibrinogen to fibrin. It is used topically to stop bleeding from smaller blood vessels in some surgical operations, especially in plastic surgery and neurosurgery. It must not be injected intravenously or allowed to enter large blood vessels since extensive intravascular clotting may occur.

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GRANTS FOR GERIATRICS STUDIES RENEWED

The American Geriatrics Society has announced the renewal of three $1,800 grants to stimulate more extensive study by resident physicians of the medical problems of the aging, to cover the period, July 1965 to June 1966. Known as the Lederle Residency Supplements, the grants will be used to augment the salaries of residents interested in geriatrics. Funds are donated by Lederle Laboratories, Division of American Cyanamid Company.

Application for the Lederle Residency Supplements should be addressed to the Chairman, Fellowship Committee, American Geriatrics Society, 10 Columbus Circle, New York 19, New York. Deadline for applications is May 1, 1965. Announcement of the grantees will be made at the Society's annual meeting in New York City in June.

The State of Wisconsin

DEPARTMENT OF PUBLIC INSTRUCTION

MADISON, WISCONSIN

ANGUS B. ROTHWELL
STATE SUPERINTENDENT

BUREAU FOR HANDICAPPED CHILDREN
JOHN W. MELCHER, DIRECTOR
ASSISTANT STATE SUPERINTENDENT
110 NORTH HENRY STREET
MADISON 53703

NEW MEDICAL CARE PROGRAM

ANNOUNCEMENT OF THE BUREAU FOR HANDICAPPED CHILDREN

The Bureau for Handicapped Children has extended its program of purchasing specialized medical care to include some congenital conditions requiring extensive surgery and prolonged care that has not been covered heretofor, particularly in the area of neurosurgery and urology. The Bureau is also including children with serious eye pathology which requires specialized surgery if performed by a board-certified ophthalmologist. Artificial eyes can also be purchased on the recommendation of the ophthalmologist. Funds are not available for glasses.

These programs include payment for an initial examination by the appropriate specialist as well as payments for surgical procedures, laboratory work, and x-rays requested by the specialists. It also includes payment for the services of a board-certified anesthesiologist at the time of surgery. Hospital costs and medications will not be included.

Eligibility for these services will be based on the family's financial situation as determined by the Bureau and the specialist's willingness to accept the Bureau's fee as payment in full. The fee schedule used is that of the Wisconsin Physicians Service Plan Schedule A.

Ordinarily the Bureau requires that authorizations for financial assistance be made prior to any service being given. It is recognized, however, that some of these children will require surgery immediately after birth, before eligibility can be determined and the necessary authorizations provided. In these cases the Bureau will consider payment if advised within 10 days after the surgery is performed and the family is found to be financially eligible. Whenever possible, prior authorization should be obtained.

Since the Bureau program does not include all congenital conditions, although at a later date might be extended to include other disease entities, any inquiries regarding this new program in relation to a particular child should be directed to the Medical Director, Bureau for Handicapped Children, 110 North Henry Street, Madison, Wis. 53703.

PATRICIA MCILLECE, M.D.
Medical Director

W. P. CURRAN, M.D.
Antigo, Wisconsin

Woman's Auxiliary

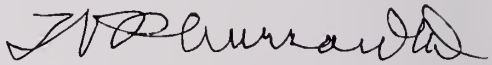
■ THIS BEING MY last opportunity to utilize the President's Page during my term of office I am taking this occasion to exemplify an organization which has been of immense help to our State Medical Society over a number of years. I refer to the Woman's Auxiliary to the State Medical Society of Wisconsin.

As we all realize Medicine is in trouble, both on a local and national basis, due partly to faults of our own, and also unsolicited aid from outside of Medicine in legislation concerning our way of life. During the past two years, I have had the opportunity to closely observe the work being done for us by the women of our Auxiliary. For an organization representing approximately 1,834 members in Wisconsin, its work has been tremendous. The officers are dedicated people who give of their time, energy, and money, with no thought of personal recompense. I am surprised at how well their programs are carried out on their limited budget. I know that the current president, those in the past, and those to come, are making a personal sacrifice, dollar-wise; and I also know that the physician husbands of these people have contributed to their wives' expenses.

During Operation Hometown in the State of Wisconsin, practically 90 per cent of the work and arrangements for public meetings was done by the Auxiliary on a local and state basis. They also met as groups in their homes and homes of their friends to try to tell Medicine's side of the story regarding medicare and other federal legislation pertaining to Medicine. They are doing a good share of the work, which we as physicians should be doing, in opposing legislation which we do not approve. Again, the work done during the Salk Vaccine Programs in the State and other programs, health-wise, have been made much easier for us physicians because of our wives' interest in our way-of-life.

Another example of help to Medicine, both on a local and national basis, is the aid given to medical education through donations to AMA-ERF. These monies are raised through memorials, sale of stationery to members, and various benefit functions. The Auxiliary also is interested in medical career education, consisting of nurse scholarships and health career conferences at hospitals, colleges, and high schools. The amount of money contributed to medical education by the Auxiliary, both in our State and on a national basis, may cause the numerical superiority of physicians to blush when a comparison of contributions is made.

Being a member of the Auxiliary tells the public that the wife of a physician is proud to be associated with her husband's professional group. There is no doubt that a well-informed, well-indoctrinated Auxiliary member is a good representative for us, public relations-wise. I hope all of the physicians in the State, numbering approximately 4,000, will give this matter some consideration and will encourage memberships in the Auxiliary of those wives who are not now members of their local auxiliaries. I also hope that all of us, as I am doing now, thank them for the help they have given us in the past; and I hope that they will continue to act as our friend of Medicine in the future.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Regulation Needed

■ IT'S BEEN A YEAR and a half since a lone gunman with a mail-order rifle ended the life of a president of the United States. In all that time, despite the public clamor for effective controls over the sale and use of firearms, Congress has done nothing to prevent a recurrence of the tragedy.

While President Kennedy is probably the best known and, for the nation, the most tragic victim of the present unbridled availability of firearms, medical personnel and police departments are painfully familiar with the day-to-day tragedies resulting from the misuse and malicious use of guns. In an article in HARPER'S, December 1964, Carl Bakal reports that more than 17,000 persons are shot to death each year in the United States. This figure includes more than half of the 8,500 reported murders, half of the estimated 22,000 suicides and about 2,000 accident victims.

Shortly after the Kennedy assassination, no less than 18 bills aimed at controlling the sale of firearms were introduced in Congress. By August of last year all of them were buried in committee, and the Congress adjourned without taking any action on the matter.

Most citizens favor some kind of firearms control. J. Edgar Hoover, who should know, favored control legislation; in Congress support came from both Democrats and Republicans; a January 1964 Gallup poll showed nearly 8 out of 10 persons in favor of a law requiring a police permit to buy a gun. More recently, a survey by a television station in Chicago indicated that over 70 per cent of the respondents favored such a law, and more than half of those who owned guns were in favor. Yet the will of what appears to be a majority of the citizens of this country, as well as a clear requirement for public safety, has been frustrated by the effective lobbying action of a small group of sportsmen, gun clubs, firearms manufacturers, and "patriotic" organizations.

Those who oppose firearm control legislation base their objection on the second amendment of the Constitution which guarantees "the right of the people to keep and bear arms." Although the amendment referred to the right to bear arms as members of a militia, as a reading of the *entire* amendment makes clear, the gun-lovers and their friends interpret it to authorize some kind of knight-like posture of individual resistance to tyranny. Nevertheless,

using their misconception of the second amendment as gospel the firearms lobby has struck down any kind of systematic federal control of firearms.

The second amendment should not be used to prevent the establishment of controls that are undeniably necessary for the public welfare. Anyone, nowadays, can buy a shotgun or rifle, either in his own hometown or by mail order. In only nine states is a permit required to purchase a pistol or a revolver. Although the federal government licenses dealers in firearms who sell interstate, such licenses can be obtained virtually for the asking. In the absence of federal action in this important area, the state of Wisconsin has an obligation to protect its citizens by passage of firearms control legislation. To prevent lethal weapons from falling into the hands of irresponsible, demented or vicious persons, laws must be passed to license their use and to control their sale. Just as the state requires an operator's license of all who drive automobiles, the state must insist that those who use firearms be likewise identified, tested, and qualified. Arms and ammunition should be sold only to those properly licensed and therefore qualified to handle them.

While the establishment of statewide firearms control may not entirely eliminate accidental injury and death from firearms, it would put a brake on the rising rate of such hazard in an increasingly congested society. And while it might mean nothing in statistical terms to the homicide rate in Wisconsin, licensing legislation could deter the one single tragedy that might senselessly turn the whole course of history again.

Firearms control legislation is desirable and necessary, and Wisconsin should take the lead in passing it.

—D.N.G.

GUEST EDITORIAL: "The Best Butter" . . . Frederick J. Spencer

The avalanche of medical specialism is unquestionably, if somewhat unhappily, a necessary trend in modern medicine. The teaching of the medical specialties is therefore well established in the clinical years in medical school. Many efforts have been made to counteract the limited teaching of the broader aspects of medical practice during this stage of the student's career.

The treatment of the "whole patient" is an idea as old as medicine itself. The "whole patient" of the 20th century, however, is the target of environmental onslaughts which were not envisioned by Hippocrates when he wrote of the *Airs, Waters, and Places* of ancient Greece. The radiation of Los Alamos and the Los Angeles smog are by-products of civilization.

As Professor John Ryle pointed out, man is part of society as *socius*—a fellow—and as a unit of *societas*—his community. The holistic approach to medical care is being met at the Medical College of Virginia by a revised curriculum which includes the constant reminder that man is part of his total environment, whether it be physical and biological, or social, economic, and cultural. In doing so, full use is made of the unlimited opportunities of personal contact between student and patient which exist in the clinics of the College.

It is, of course, possible to emphasize the breadth of medical education to the detriment of teaching the crafts of the specialties. One can come to a point where it is impossible to see the trees for the forest. The aim of the Medical College of Virginia, therefore, is to maintain a dynamic equilibrium of specialist practice and humanitarian precept balanced upon the fulcrum of solid educational principles. Without any of these three components, it is unlikely that medical graduates can assume the role of the "compleat physician" in modern society.

The vast number of individuals who comprise the modern medical care team look to the physician for leadership. During his student days, he must gain some insight into his responsibilities not only to the public but also to the members of paramedical groups. Despite using "the *best* butter," the March Hare could not rejuvenate the battered mechanisms of the Mad Hatter's watch. In the trying times facing medicine in 1964, the physician must act as a catalyst to "the *best* butter" of his colleagues in the other health professions. This may be accomplished only by teaching the concept of "holism" embodied in the writings of the great South African soldier-politician, Jan Christian Smuts.

The swing of the pendulum between "holism" and "partism" in medicine is wider at this moment than ever before. We cannot mimic the dormouse and put our heads in teapots; this is the surest method of producing the specialist physician who "knows more and more about less and less." We must return to the study of the natural history of health and disease. The ultimate goal of the true physician is to modify this to the maximum benefit of the patient as a small, but significant, part of the total environment.—Reprinted from *International Medical Digest*, July 1964.

Minutes of the Council Meeting

MADISON, DECEMBER 12, 1964

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 7:50 p.m. on Saturday, Dec. 12, 1964, at Society headquarters.

Voting members present were Doctors Schulz, Davis, Dessloch, Blanchard, Kief, Fox, Bell, Mason, Ekblad, Lee, Chojnacki, Van Hecke, Wright, Past President Egan, President Curran, and Speaker Callan. Others present were President-elect Houghton; Doctor Simenstad, AMA Trustee; Doctor Picard, AMA alternate delegate; Messrs. Crownhart, Ragatz, Reynolds, Hansen, Salt, Koenig, Murphy, Kluwin, White; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Curran-Ekblad, carried, minutes of the Oct. 9, 1964, meeting were approved.

3. Executive Contracts of Employment

On motion of Doctors Ekblad-Chojnacki, carried, the Finance Committee was asked to consider the matter and report its recommendations to the Council.

4. Report of the Wisconsin Delegation to the AMA; Action on Newsletter

Members of the Wisconsin delegation present and who had attended the Miami meeting were Doctors Picard, Bell, and Fox. Between them the highlights of the meeting were reported, with particular reference to Doctor Ward's presidential address and the AMA educational campaign conference to be held on December 13.

The report was accepted on motion of Doctors Egan-Mason, carried.

Doctor Kief referred to the newsletter which had been sent to a representative group of members on behalf of the Councilors and Officers and discontinued several years ago because of cost; also discontinued were written reports by the AMA delegates because of information disseminated to the membership through AMA NEWS, journals, and the like. He recommended that sometime in the future a newsletter be reinstituted, informing the members of Council actions and impressions of the AMA delegation arising from its meetings. Chairman Fox stated agreement with the suggestion of a newsletter, and in particular that information on the educational campaign should reach the membership.

Doctors Kief-Chojnacki moved that a newsletter concerning the proceedings of the AMA delegates at Miami go out to the general membership of the State Medical Society. The amendment suggested by Doctor Ekblad that such newsletter be discussed at regular county medical society meetings was accepted in the motion.

Doctor Blanchard questioned why the information is not published in the JOURNAL if a newsletter was discontinued because of cost, and some were doubtful that a separate mailing, in addition to the JOURNAL and AMA NEWS, would receive the attention it deserved, that word of mouth is a better means of communication and it is the councilor's duty to inform the district membership of actions taken at various levels. Doctor Van Hecke also called attention to the recommendation of the Executive Committee in its minutes of November 22 with reference to informational meetings on Kerr-Mills.

Chairman Fox stated the motion as follows: that the report of the delegates to the AMA and a report of action of the Council and its Executive Committee be forwarded to each county medical society with the recommendation that they immediately institute county meetings or, if not practicable, councilor district meetings to the effect that each member in the Society be aware of the implications of the Kerr-Mills bill, the King-Anderson bill, and what to do about it. Motion carried.

5. Creation of Position of Historian

By agreement, this matter was laid over to a future agenda.

6. Reconstitution of Committee on National Legislation

A motion to terminate the present committee with thanks and retain the matter of federal legislation within the Council for the present lost; and on motion of Doctor Kief, seconded and carried, any action will be held until after a report is received on the December 13 national conference.

7. CES Foundation

The Secretary asked that the Council consider for later discussion what appropriate mechanisms might be utilized to remind physicians periodically of the possibility of including the Foundation as a beneficiary in their wills, in the disposition of hobbies and collections, and the like.

8. Popp Student Loan Fund

As a matter of information, the Council was informed that Albert Popp, M.D. of Milwaukee had established a student loan fund in his name with an initial contribution and the expectation of further additions.

9. Wisconsin Health Council, Inc.

Mr. Hansen, who succeeded Earl Thayer as executive secretary, informed the Council of plans for a health careers recruitment program to be operated within the framework of the Wisconsin Health Council. Interested organizations will meet at the Society on December 16 and their support, including financial assistance, will be solicited. The Wisconsin Hospital Association had committed an initial grant of $2,500.

The Council reviewed what the Society now contributes to the Wisconsin Health Council in staff time and various office facilities, and concluded it was at least the equivalent of what the hospital association plans to contribute toward staffing the project. There is no assurance at this time what it or other organizations will do in the future to finance the program on a continuous basis.

On motion of Doctors Mason-Kief, carried, the Council authorized continuation of Society participation as in the past.

10. Council Award

It was moved, seconded, and carried that the Council cast a unanimous ballot for the nominee to receive the award in 1965, per mailing of Oct. 20, 1964.

11. Status Report on Osteopathy

The Secretary, reporting in the absence of Doctor Frank, chairman of the Planning Committee, said in substance that the matter is now one of local jurisdiction pursuant to the mailing to county societies of House action at the fall session.

12. Commission on State Departments

A. Division on Visual and Hearing Defects

(1) Guides on Impairment of Vision

On motion of Doctors Mason-Van Hecke, carried, the Council approved a proposed letter to the Industrial Commission concerning workmen's compensation cases involving visual problems and recommended procedures.

(2) Interpretation of Optometry Bill 686, S.

On motion of Doctors Chojnacki-Blanchard, carried, the Council approved the basic concepts suggested by the Division in regard to the position of the Society on optometry Bill 686, S., which amends Chapter 507 of the Wisconsin Statutes.

B. Division on Nervous and Mental Diseases

Mr. Reynolds reported that the chairman of this Division has requested a later opportunity to present its proposals to the Council regarding future activities.

C. Division on School Health

(1) Recommended Guide for "Athletic Disqualification—Junior and Senior High School Level"

On motion of Doctors Mason-Blanchard, carried, the Council approved a statement for publication in the January 1965 Blue Book issue of the WISCONSIN MEDICAL JOURNAL, with reprints distributed to members.

(2) AMA Statement on "Exercise Fitness"

On motion of Doctor Chojnacki, seconded and carried, the Council approved purchase of the AMA pamphlet for distribution to education officials.

(3) Distribution of Health Examination Report

On motion of Doctors Lee-Blanchard, carried, the Council approved distribution to appropriate educators of the form on which physicians report to the school on significant findings of health examinations, containing space for school personnel to indicate action taken on recommendations made.

(4) Resolution on Physical Education Programs in Schools

On motion of Doctors Curran-Ekblad, carried, the Council adopted the following resolution as proposed by the Division on School Health:

"WHEREAS, Exercise is an essential element in achieving physical fitness and total fitness; and

"WHEREAS, Practices and patterns established in early life are strong determinants in maintaining levels of fitness in adult life; and

"WHEREAS, There are so many influences in the daily lives of school age children which interfere with the natural tendency to keep and maintain bodily efficiency; and

"WHEREAS, The school, along with the family and the community, has a concern with the fitness of our youth; and

"WHEREAS, The physical education programs in schools have been the concern of the educator, the physician, the parent, and the community, to make them more effective and expand their benefits to all students; and

"WHEREAS, A statutory requirement dealing with the amount of time devoted to physical education has been removed, and could result in de-emphasis of physical education programs in our schools; now therefore be it

"*Resolved,* That physicians, individually and through their county medical societies, direct their attention particularly to that portion of the curriculum devoted to physical education with emphasis on: (1) adequate allotment of time devoted to the subject, (2) equal emphasis on programs for both boys and girls, and (3) more use of facilities during out-of-school time."

(5) Communications on Health Education

On motion of Doctors Chojnacki-Kief, carried, the Council approved a letter for signature by President Curran to presidents of state colleges and universities concerning recommended standards in health education courses for teachers.

(6) Publication of School Health Policy Statements

The Division recommended that resolutions of the Society on health and physical education be combined in a pamphlet and distributed to school administrators.

This was approved on motion of Doctors Chojnacki-Kief, and the suggestion of Doctor Van Hecke accepted that officers of county medical societies be notified when such communication is sent.

D. Division on Public Assistance

The Commission on State Departments, on recommendation of this Division, reported the tabling of Resolution No. 1 introduced by the Fond du Lac County Medical Society in October 1963 concerning relationships with the State Department of Public Welfare.

Such action will be reported to the House of Delegates for the record.

13. Commission on Hospital Relations and Medical Education

Mr. Reynolds reported for information the status of two matters under review by this Commission earlier in the week:

The "Town and Gown Symposia" under the new title of "Medical Education and the Practice of Medicine in Wisconsin" are scheduled for March 27 in Milwaukee and March 28 in Madison.

A proposed model contract for hospital staffs will be submitted to the Council for its consideration.

14. Report of Executive Committee

Doctor Fox reviewed with the Council the minutes of the November 22 meeting of the Executive Committee, which are incorporated herein with such action as taken by the Council appropriately noted:

All members were present at the meeting in Madison on Nov. 22, 1964: Doctors Curran, Houghton, Egan, Fox, Bell, Frank, Dessloch, Nordby, and Van Hecke. Also present: Messrs. Crownhart, Koenig, Murphy, Kluwin, White; Mrs. Anderson and Miss Pyre.

a) Approval of Minutes

On motion of Doctors Frank-Nordby, carried, minutes of the Sept. 12, 1964, meeting were approved.

b) Appointment to Committee on Cancer

To represent the eighth councilor district, Doctor Curran appointed Raymond J. Rogers, M.D., Marinette, effective Jan. 2, 1965, when his membership transfer from Michigan will be completed.

c) 1965 Annual Dinner Program

On motion of Doctors Dessloch-Bell, carried, planning of entertaining for the annual dinner was deferred to the President and President-elect.

d) People to People Tour of Medical Facilities of Latin America

An erroneous report in AMA NEWS that C. H. Crownhart would lead a tour group was corrected in the subsequent issue.

The committee discussed the proposed tour, on which the Secretary had been contacted by the Wisconsin Commissioner of Agriculture, and agreed that no action be taken to promote it.

e) Economic Opportunity Act of 1964

An invitation had been received from Governor Reynolds to nominate a representative for a Wisconsin Advisory Council.

On motion of Doctors Egan-Nordby, carried, the committee requested that the president make such a nomination if he finds it feasible or practical at this time.

f) Disposition of Excess Copies of Booz–Allen–Hamilton Report

Approximately 750 copies were not distributed or have been returned by members. The Secretary proposed that a copy be bound into the transcript of proceedings of the House of Delegates, about half destroyed now and the balance kept for a year for further requests and then destroyed.

On motion of Doctors Dessloch-Bell, carried, the committee approved retention of an appropriate number for the archives and the rest destroyed.

g) Internal Revenue Service Examination

Mr. White explained that IRS had selected the year 1961 for its examination of the Society's operation of WPS, and the statute of limitations expires May 15, 1965. It feels this will not provide sufficient time to conclude the question of a tax assessment, and asks that the period be extended to June 30, 1966.

Messrs. White and Murphy presented various considerations in deciding whether to grant the extension, and both recommended that it be done.

On motion of Doctors Dessloch-Nordby, carried, the committee so recommended to the Council.

h) Report on Civil Service Commission Review of Employment Policies

Mrs. Anderson reported what the Society has done in the past to comply as an "equal opportunity employer," and the few suggestions made in a recent review by the Civil Service Commission to give further evidence of compliance.

On motion of Doctors Bell-Dessloch, carried, the report was accepted.

i) Invitational Conference on Health Care—UW Medical Center

A report of staff reactions had been distributed to the Council and the Commission on Medical Care Plans.

Doctors Houghton and Egan had also been in attendance and added their comments. No action was taken, and the report was accepted.

j) Appearance of H. L. Toser

On his own request, Mr. Toser appeared before the committee to express dissatisfaction over assignments received since his return to the status of insurance consultant in May of 1964 when a full-time Insurance Director had been appointed on recommendation of the selection committee of the Commission on Medical Care Plans. This committee was comprised of Doctors Nordby, Goldstein, Mason, and Dessloch.

Mr. Toser stated that the assignments did not command his talents. He stated that he had felt ignored and expressed other matters of concern to him. The discussion lasted an hour and a half, with participation by most of the doctors present and by Mr. Crownhart. No action was taken by the committee.

Mr. Toser expressed his loyalty to the Society and his best wishes as he leaves it on November 30 to take a position as Director of Sales for Sentry-Hardware Mutuals at Stevens Point.

k) AMA Communication on Quackery

This communication concerning creation of an AMA Committee on Quackery and its activities and objectives was referred to the Commission on Public Policy.

l) AMA Conference on Kerr–Mills

The AMA will sponsor a national conference on MAA programs in Chicago on Jan. 9–10, 1965, and pay expenses of one individual from each state. Mr. Crownhart suggested that Doctor Houghton, who will be assuming the office of President during the next legislative session, be the physician representative.

Discussion evolved into what steps should be taken to fully inform members and others on benefits of the Wisconsin program.

Doctor Curran suggested meetings on a councilor district basis, open to anyone wishing to attend. Mr. Crownhart thought this should be on a trial basis in one or two districts.

The motion finally made by Doctors Van Hecke-Egan, and carried, was that with all urgency county medical society secretaries be informed that they should set up informational meetings, using whatever available sources they have, including the local welfare administrator and such aid as the office of the State Medical Society is able to provide, and where several counties are in a councilor district and can do so, that they join together to cut down the number of meetings if at all possible, and that the councilor of each district report back to the Council.

m) Report on Physician in Financial Need

Mr. Kluwin reported information he had secured in interview with the wife of a hospitalized physician and the family's financial situation.

On motion of Doctors Egan-Van Hecke, carried, the committee asked that more information be secured before the Council meeting, and recommended that the Council work out a mechanism for taking care of this type of case.

Council Action: Such additional information as was available was discussed with the Council, as well as the circumstances of another physician who had recently applied for financial assistance by way of a loan. It was the general consensus that the Society, through its Foundation, can do no more than provide emergency cash for essential needs in these situations and cannot consolidate indebtedness.

On motion of Doctors Chojnacki-Van Hecke, carried, the Council asked that prior to the Christmas season an appeal be made to the membership for funds for physicians in need and that this money be given to the CES Foundation for this purpose.

On motion of Doctors Curran-Van Hecke, carried, the matter was referred to the Finance Committee to set up mechanisms for the future.

n) Medicine and Pharmacy

On motion of Doctors Dessloch-Fox, carried, the committee authorized arrangement of a meeting with representatives of the Wisconsin Pharmaceutical Association, similar to past joint meetings with the Wisconsin Hospital Association.

o) Index of Official Actions

On motion of Doctors Fox-Frank, carried, the committee referred to the Finance Committee for fiscal review the proposal that official actions of the State Medical Society be published, the project being assigned to an independent contractor.

p) Miscellaneous

The committee was reminded of the Presidential Citation and the Hospital Service Award, no nominees for which have been offered.

Doctor Fox asked whether legal counsel could report at the Council meeting on the status of professional corporations and IRS approval.

Council Action: In view of the late hour, the report of legal counsel will be circulated to the Council.

Doctor Dessloch suggested that the format of the interim session of the House be reconsidered. He thought it should be an educational program, with a report by the Commission on State Departments at one session, the Commission on Medical Care Plans at another, etc.

The committee agreed with Doctor Egan's suggestion that the committee not hold a separate meeting in December.

Council Action: On motion of Doctors Ekblad–Kief, carried, the report of the Executive Committee was accepted as a whole.

15. Life Membership Application

The Secretary reported receipt of a check for $1,000 to the Endowment Fund and application for life membership pursuant to Section 3, Article IV of the Constitution.

While an Endowment Fund was never created and no life memberships have been granted under this section, and action is pending for its repeal by the House of Delegates, he felt that the application could not be denied and suggested that the check be deposited to the charitable account of the Foundation.

There was no contrary action by the Council.

16. Area Hospital Planning

Doctor Fox reported a suggestion by Doctor Galasinski that consideration be given to creation of an area hospital planning committee.

On motion of Doctors Curran–Blanchard, carried, this was referred to the Planning Committee and a report requested at the next meeting.

17. Adjournment

The meeting adjourned at midnight.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

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COUNTY SOCIETY PROCEEDINGS

DODGE

Dr. Jerome F. Szymanski was guest speaker for the March 25 meeting of the Dodge County Medical Society at Beaver Dam. Doctor Szymanski, who is a psychiatrist at Winnebago State Hospital, presented a discussion of facilities available in this area with particular reference to consultations, referrals, and treatment. A question and answer period followed.

A short business session which preceded the program was conducted by the president, *Dr. N. H. Schulz*. A Horicon physician, Doctor Schulz was installed as president at the Society's January meeting, when *Dr. Theodore Rowan*, Beaver Dam, also took office as secretary.

The practical aspects of pediatrics were discussed by *Dr. C. D. Schoenwetter*, Madison pediatrician, at the Society's meeting on February 25 at Beaver Dam. Endocrine problems were emphasized, particularly the adrenal genital syndromes and thyroid dysfunction.

KENOSHA

A buffet supper at the Elks Club in Kenosha preceded the meeting of the Kenosha County Medical Society April 1. Speaker was R. J. Steininger, manager of insurance for Bucyrus–Erie of South Milwaukee, who discussed Milwaukee County's experience in the cost analysis of the industrial health program.

VERNON

Vernon County physicians, and a few from the adjoining area, on April 1 started an eight-week psychiatric course given by the University of Wisconsin Medical School Department of Psychiatry, with *Dr. B. H. Glover* in charge. The physicians are taking the course for 20 hours of postgraduate training. It is being presented every Thursday evening during the eight-week period.

Vernon and Grant Counties are the first in the state to start this specialized instruction, which is being made possible through a grant of the National Institute of Mental Health.

WALWORTH

Because bad roads prevented the attendance of the scheduled speaker, *Dr. Lawrence R. Prouty* of Madison, Walworth County Medical Society members had a longer business session than usual when they met March 18 at Fontana. Wives of members were present for the dinner meeting.

WINNEBAGO–OUTAGAMIE–WAUPACA

The Winnebago, Outagamie, and Waupaca County Medical Societies held a joint dinner meeting April 15 at Neenah, with Dr. Frederic Gibbs of Chicago as speaker. A graduate of Johns Hopkins University School of Medicine, Doctor Gibbs was associated with Harvard University for 13 years before joining the University of Illinois College of Medicine faculty. He is professor of neurology and director of electroencephalography.

Doctor Gibbs is a recipient of the Lasker prize for outstanding work in the development of drug therapy for victims of epilepsy. He has been a consultant at Theda Clark Memorial Hospital, Neenah, since 1948 when the electroencephalogram department was established.

WOOD

Dr. J. W. Schaller of Wisconsin Rapids spoke on the subject "Polymerization of Opaque Contrast Agents" at the meeting of the Wood County Medical Society April 8 at Wisconsin Rapids. "Renal Calcinosis" was the topic of *Dr. R. L. Johnson*, also of Wisconsin Rapids. The Society's next meeting is slated for September 9 at Marshfield.

Physicians whose names appear in italics are members of the State Medical Society.

COUNTY SOCIETIES DONATE TO CES FOUNDATION

Four county medical societies have donated funds to the CES Foundation of the State Medical Society, totaling $15,850.

Outagamie County Medical Society in March presented a check in the amount of $15,000 representing the proceeds gathered from excess donations during the Sabin on Sunday programs, where Outagamie citizens were provided the opportunity for polio immunization. The funds were earmarked for loans to students in the fields of medicine, dentistry, nursing, and pharmacy. The loans will be administered by the Foundation as a part of its Student Loan Program.

Another $500 check was also presented in March by the Columbia–Marquette–Adams County Medical Society to the CES Foundation. The check, a yearly donation by the county society, was not earmarked for any special phase of the Foundation's activities.

Late in 1964, the Vernon County Medical Society contributed $250 to the Charitable Account of the Foundation following President Curran's plea for help to disabled physicians and their families.

Earlier in 1964, and not previously reported, the Ozaukee County Medical Society gave $100 to the CES Foundation for unrestricted use.

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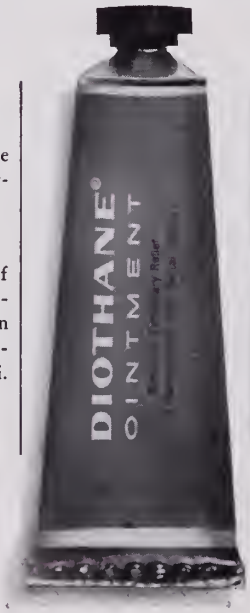
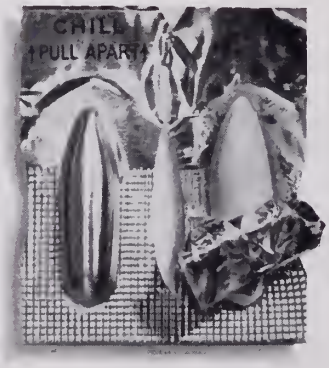
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





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COMPOSITION:
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Annual WATA Meeting

Dr. James M. Wilkie, Madison, was chosen president-elect of the Wisconsin Anti-Tuberculosis Association at its annual meeting April 1–2 in Milwaukee. Harry G. Marsh, Madison, took office as association president, and other new officers are *Dr. Helen A. Dickie*, Madison, vice-president; *Dr. Elwood W. Mason*, Whitefish Bay, secretary, and James P. Fitch, Milwaukee, treasurer.

As keynote speaker for the meeting, Dr. James L. Goddard, U.S. assistant surgeon general and chief of the Communicable Disease Center at Atlanta, Ga., told the group of about 325 in attendance that under the surgeon general's task force program begun last fall, studies are being conducted to determine the high risk factors. Core of the tuberculosis problem in this country is to find out who among those infected is most likely to develop an active case of the disease, Doctor Goddard said.

Other physicians on the program included *Dr. William W. Stead*, *Dr. Richard P. Jahn*, *Dr. E. R. Krumbiegel*, and Dr. Avrum B. Organick, all of Milwaukee, *Dr. John K. Shumate* and Doctor Dickie, Madison.

Two retired nurses, Ella L. Neumann, Lake Geneva, and Iva Louise Hartmann, Janesville, received the WATA distinguished service award.

On April 1, members of Wisconsin's local TB associations and representatives of public health agencies around the state discussed eradication-slanted programs for local communities. Speakers included Dr. Joseph C. Mulhern, Milwaukee, and *Dr. Raymond H. Evers*, Plymouth.

Wisconsin Student Nurse Association

More than 400 student nurses representing the state's schools of nursing were in Fond du Lac March 20 for the 31st biennial convention of the Wisconsin Student Nurse Association.

Miss Bonnie Janov, 1964–1965 president of the association, seated the following officers for 1965–1966: Miss Valeria Simpkins, Janesville, president; Miss Joey Neiman, Wausau, first vice president; Miss Kathy Perlock, Marshfield, second vice president; Miss Marie Wanerski, Wausau, treasurer, and Miss Janov, president's adviser.

Fond du Lac physicians presided over special interest workshops, including "Deafness, Its Modern Concept and Treatment," with *Dr. Darius K. Shahrokh* of the Fond du Lac Clinic as guest speaker, and "Modern Cancer Research," featuring *Dr. N. O. Becker*.

Keynote speaker was Miss Mary Bartosic, acting director of nursing education at Winnebago State Hospital.

Milwauke Academy of Medicine

"Etiological Factors in Toxemia of Pregnancy" was the subject discussed by Dr. Charles A. Hunter

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Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

as speaker for the meeting of the Milwaukee Academy of Medicine April 20 at the University Club of Milwaukee. Doctor Hunter is professor and chairman of the Department of Obstetrics and Gynecology, School of Medicine, University of Washington. At 4 p.m. the day following, Doctor Hunter presided over a clinical conference at Milwaukee County Hospital, with members of the Milwaukee Gynecological Society and their guests invited to attend both the conference and a dinner meeting.

Dr. E. S. Gurdjian of Wayne State University, Detroit, is scheduled to speak at the Academy's meeting on May 18, on the topic, "Surgical Treatment of Stroke Resulting from Extracranial Occlusive Disease."

Portage County Unit, ACS

Following the public showing of two films sponsored by Portage County Unit, American Cancer Society, March 29 in Stevens Point, a panel of physicians participated in a discussion of the effects of smoking. Taking part were *Drs. Albert M. Kohn*, *R. A. Eckberg*, *Robert H. Rifleman*, and *John F. Riordan*.

Wisconsin Heart Association

A public heart forum on children's heart diseases sponsored by the Wisconsin Heart Association was held April 2 in Ladysmith. Featured were three specialists from the Marshfield Clinic, *Dr. Dean Emanuel*, adult cardiologist, speaking on the theme, "Recent Advances in Acquired Heart Diseases;" *Dr. Richard D. Sautter*, cardiovascular surgeon, "Surgical Correction of Acquired and Inborn Heart Defects;" and *Dr. George G. Griese*, pediatric cardiologist, "Rheumatic Fever" or "Diagnostic Techniques of Inborn Heart Diseases."

Cancer, Nursing Conference

The fourth annual "Cancer and the Nurse" conference, cosponsored by the American Cancer Society, Wisconsin Division, and the University of Wisconsin Medical Center, was held April 3 at the Wisconsin Center, Madison.

Headlining the program was a presentation, "The Assessment of Nursing Needs of Patients," by Miss Doris Diller, professor of nursing at Skidmore College, New York City. Keynote speaker was *Dr. Anthony Curreri*, who discussed "Cancer Research." Other University of Wisconsin Medical School faculty members who spoke were *Dr. Fred Ansfield*, "What's Going on in Cancer Chemother-

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Sanborn will continue to maintain engineering, manufacturing, sales, and service headquarters in Waltham, Massachusetts. The same intimate knowledge of the instrumentation requirements of the medical profession will continue to guide the management of SANBORN as an H-P Division.

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apy?"; *Dr. Frederic Mohs*, "Chemosurgery Techniques;" *Dr. Frank Weston*, "A Physician Looks at Nursing Care of the Chronically Ill and Advanced Patient;" and *Dr. Robert Samp*, "Patients Are People."

During the morning program a panel consisting of *Dr. Sanford Mackman*, Rose Chioni, R.N., Ph.D., and Miss Diller discussed colostomy, with Doctor Samp serving as moderator.

Milwaukee County Medical Assistants

Dr. Miles Smith spoke on the St. Mary's Burn Center at the April 22 meeting of the Milwaukee County Medical Assistants Society, at the Federation of Women's Clubs clubhouse in Milwaukee.

At their meeting on March 18, members of the Society heard Mr. Robert E. Atkins, coordinator of civil defense for the city of Milwaukee, explain the stocking of local shelters.

Milwaukee Academy of General Practice

Dr. Eugene M. Kay took office as president of the Milwaukee Academy of General Practice at the association's annual meeting in February. Chosen president-elect was *Dr. Samuel A. Graziano.*

Also elected were *Dr. John F. Cary*, secretary, and *Dr. Morris Mitz*, treasurer. Named to three-year terms as directors were *Drs. Peter Casey, Ervin Hansher, David Mehigan,* and *Stanley Zawodny. Dr. John A. Kelble*, immediate past president, will serve on the board of directors in an ex-officio capacity.

The association also elected *Dr. William C. Curtis* to serve until 1968 as a delegate to the Wisconsin Academy of General Practice, and *Dr. Edmund Schmidt*, as alternate delegate.

Juneau County Unit, ACS

Speaker for the Cancer Crusade "kick-off" meeting of the American Cancer Society's Juneau County unit, on March 9 in Mauston, was Dr. James M. Price, Madison, professor of surgery at the University of Wisconsin Medical School. Doctor Price spoke of the tremendous facilities for cancer research at the University and reported that last September the American Cancer Society made a grant of nearly $400,000 for cancer research projects.

THE DRUG INDUSTRY leads U.S. industry in research and development. According to the National Science Foundation, the drug industry accepts the least amount of federal research funds; has the highest percentage among all industries for basic and applied research; has the highest ratio of company-financed research to net sales, and has the highest amount of company-financed research per employee.

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CONTRAINDICATIONS: There are no known contraindications.

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Nicotinic Acid ..... 75 mg.
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SUPPLIED: 8 oz. bottles and bottles of 100 chew-tabs.

REFERENCES:
1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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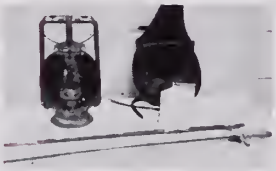
THANKS

ARCH A. ARMSTRONG, Boscobel, for the collection of artifacts memorializing your father, the late Dr. Leroy Grant Armstrong, esteemed citizen and physician of Boscobel and president of the State Medical Society of Wisconsin in 1888.

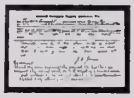


The collection, which has recently been moved from the Society headquarters in Madison to the Museum of Medical Progress in Prairie du Chien, contains items from Doctor Armstrong's military as well as his medical career. (He enlisted in the Union Forces in 1862 and served with distinction.) Included is a dress sword engraved with the words "U.S. Medical Staff;" a small Bible dated 1849 which contains, in the doctor's handwriting, the notation, "Carried Through the War 1862–1866 LGA;" and several official papers, including one from Gen. Meade's headquarters, Army of the Potomac. Part of the extensive collection, also, are black leather saddlebags, a varnished wooden bootjack, gasoline lantern, cane, razor strop, brass alcohol burner, an embossed brass powder flask, braided leather buggy whip, and numerous old books and newspapers. Of particular interest to physicians are two early-type syringes, one of hard rubber or bakelite, the other a straight plunger with no needle.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS



MEDICAL MUSEUM

NEWS OF WISCONSIN PHYSICIANS

Marquette School of Medicine Names Dr. Gerald A. Kerrigan Acting Dean

Dr. Gerald A. Kerrigan, associate professor of pediatrics, is now acting dean of Marquette University School of Medicine, Milwaukee. Announcement of his appointment, which was effective March 1, was made late in February by the Very Rev. William F. Kelley, S.J., Marquette president.

Doctor Kerrigan succeeds *Dr. John S. Hirschboeck*, who has been serving most of the last two years as dean and vice-president of the medical school and secretary of the board of directors. Dean since 1947, Doctor Hirschboeck now will concentrate on development of the proposed medical center program for the medical school and community.

Doctor Kerrigan, a 1946 graduate of Harvard University Medical School, has been on the Marquette medical faculty since 1956. He is also an attending physician at Milwaukee Children's Hospital. A native of New York City, he received his B.S. degree from Harvard in 1943, and was on the Harvard medical faculty from 1950 to 1956. He served as a lieutenant (junior grade) in the Navy Medical Corps from 1947 to 1949 at the Naval Hospital, Corpus Christi, Tex., following an internship in pathology at Boston Children's Hospital. From 1949 to 1952 he completed residency in the children's medical service of Massachusetts General Hospital, Boston.

His field of specialty is water and electrolyte metabolism. In 1960 and 1961 he did research in neonatal metabolism on grants from the United States Public Health Service.

Doctor Kerrigan was appointed acting dean with the expectation of appointment as dean later. He had been sought recently for important posts by the National Institutes of Health and by other medical schools.

Dr. Gerald Kerrigan

Dr. James Russell

Dr. Russell MC at Banquet

Dr. James C. H. Russell served as master of ceremonies at the Fort Atkinson Sports banquet March 23, when approximately 100 high school athletes in nine sports were honored.

Doctor Russell has served, without pay, as Fort Atkinson team physician for the past 18 years, and recently officially became team physician at Whitewater State University, as well as a professor at that institution, teaching anatomy and first aid.

He is chairman of the Division on School Health of the Commission on State Departments of the State Medical Society of Wisconsin; a fellow of the American College of Sports Medicine; and a member of the AMA Committee on Exercise and Physical Fitness. He is considered an authority on the prevention and treatment of athletic injuries.

Doctor Russell's selection as master of ceremonies for the banquet was, in a small way, a tribute to a man who, as a father (two of his sons were active in athletics in their high school days in Fort Atkinson), fan, physician, and school board member, has contributed much to the success of the Fort Atkinson High School sports program.

Former Wisconsin Physicians Succumb

Dr. Robert Lehmer, 48, who formerly practiced medicine in Colby, died at Ithaca, N. Y., on July 22, 1964, it was learned here recently. He was associated with Dr. A. L. Schemmer for a year and with Dr. G. G. Shields for four years at Colby.

Dr. Dennis B. Rise, 80, died Nov. 8, 1964, in Rock Island, Tenn. In 1918 Doctor Rise practiced medicine in Fayette and Lamont area. He was a practicing physician in Wisconsin and South Dakota for many years and was active as a breeder and owner of Standard breds for more than half a century. In 1963, he donated $200,000 to the University of Louisville medical school.

Dr. Leo Nash, a former River Falls physician, died at his home in St. Paul, Minn., on Dec. 1, 1964. In 1936 and 1937 he was a part-time physician to the Student Health Service at the River Falls State Teachers College. A former member of the Pierce–St. Croix Medical Society, Doctor Nash was associated with Dr. C. A. Dawson while he was in practice in River Falls. Mrs. Nash and three daughters and a son survive him.

MU Doctors to Train at Columbia

Dr. Elwood W. Mason, chief of staff at Columbia Hospital, Milwaukee, told the hospital's corporation members that Columbia has become a participant in the Marquette University School of Medicine training program for doctors specializing in surgery. Speaking at the corporation's recent annual meet-

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Physicians whose names appear in italics are members of the State Medical Society.

ing, Doctor Mason said that the new arrangement was part of the hospital's plan to improve its educational program for interns, residents, and the regular staff.

Participants in the Medical School's surgical teaching program include Milwaukee County General Hospital, the Veterans Administration Hospital at Wood, Milwaukee Hospital, Milwaukee Children's Hospital, and Columbia.

Surgical residents under the Marquette program now spend part of their training time at Columbia under supervision of the hospital's surgical staff, which is headed by *Dr. C. Morrison Schroeder* of the Medical School faculty.

Dr. Kennan Transfuses Unborn Child

A blood transfusion to an unborn infant was successfully accomplished for the first time in February at University Hospitals, Madison. Dr. Alfred L. Kennan gave the transfusion February 15 and on February 26 delivered the child. The first such transfusion was attempted by Dr. A. W. Liley in New Zealand.

Dr. Ellison Invited

Dr. Edwin H. Ellison, Milwaukee, has been invited to take part in a symposium which will be part of the program for the 64th annual meeting of the American Proctologic Society June 14–16 in Minneapolis. Subject of the symposium, which is scheduled for June 16, is "Colon and Rectal Surgery in Relationship to Surgical Programs of Medical Schools and Hospitals."

Dr. Erdlitz at Necedah

Dr. Frank J. Erdlitz, who was most recently located at Mauston and Rio, began practice in the Necedah Clinic March 1.

Husband, Wife Team at McArdle Labs Receive Award for Cancer Research

James A. Miller, Ph.D., and his wife, Elizabeth Miller, Ph.D., of the University of Wisconsin McArdle Laboratories, Madison, on April 6 were presented with the Lucy Wortham James award for "outstanding investigative work on hydroxylation of the acetylaminofluorene carcinogens." Both have Ph.D.'s in biochemistry.

The award, sponsored by the New York Community Trust in recognition of distinguished clinical and research attainment relating to cancer, is conferred through the James Ewing Society, a national organization of physicians and surgeons specializing in cancer treatment. Consisting of a scroll and honorarium of $1,000, it was presented at the Society's annual meeting in Houston.

Dr. Epstein to Madison

Dr. Stephan Epstein, who joined the staff of the Marshfield Clinic in 1936, has left his work as head of its dermatology department to continue his practice at Madison, where he is spending part of his time as a clinical professor of dermatology at the University of Wisconsin Medical School.

Dr. Sanford Back in Hillsboro

Dr. L. L. Sanford resumed medical practice in Hillsboro March 6 after residing in La Farge since July 1964.

Dr. Allen Presents Paper

Dr. John Allen, Madison, consultant in medical administration for the State Department of Public Welfare, presented a paper on "Medical Administration of Health Care Programs" before the American Medical Association national meeting on Rural Health in March at Miami Beach, Fla.

Drs. Nienhuis, Ellis ACOG Fellows

Dr. Herman D. Nienhuis, Janesville, and *Dr. John C. Ellis, Jr.*, Madison, were installed as fellows of the American College of Obstetricians and Gynecologists at its annual meeting April 4–8 in San Francisco.

Dr. Reese Receives Honorary Degree

Dr. Hans H. Reese has received an honorary doctor of medicine degree from the University of Kyushu, Japan. On an assignment received partly through the National Institute of Neurological Diseases and Blindness and partly through the Fulbright Commission, Doctor Reese spent six months as a teacher at that university and during that time organized the various researches for multiple sclerosis and muscular dystrophy. He was successful in creating a neurology department in at least four major universities, and at the University of Kyushu he established the first Neurological Institute, which parallels in its efforts the Brain Institute at the University of Tokyo.

Dr. Neupert Honored

Dr. Carl N. Neupert, Madison, was awarded the Wisconsin Hospital Association's Award of Merit in March at the group's 46th annual convention in Milwaukee. Doctor Neupert is retiring June 1 as state health officer.

Dr. Mercado at Kenosha

Dr. Roger Mercado was appointed to the Kenosha Memorial Hospital medical staff late in March. He received his M.D. degree in 1958 from the University of Santo Thomas, Manila, Philippine Islands, interned at St. Michael's Hospital, Milwaukee, and served a residency in anesthesiology at Mount Sinai Hospital, Chicago.

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Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfast.
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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PHYSICIANS SPEAK AROUND THE STATE

Dr. James F. Baumgartner, West Bend, to West Bend area chapter, American Association of Retired Persons, talk on "Medicare vs. Eldercare," April 21 in auditorium of new Washington County courthouse, West Bend.

Dr. Robert J. Samp, Madison, at the kickoff dinner meeting of the 1965 Cancer Crusade in Outagamie County, March 25 in Appleton, and at a program for Kenosha high school students with prize-winning projects in the 1965 Kenosha science fair, April 28 at St. Joseph High School, Kenosha.

Drs. *A. B. Schwartz* and Stanley Berlow, Milwaukee pediatricians, discussed doctor's role in diagnosing mental retardation at meeting of United Association for Retarded Children, Inc., March 29 at Milwaukee Children's Hospital, with *Dr. Franklin J. Mellencamp*, Milwaukeee pediatrician, serving as moderator.

Dr. F. V. Beran, Fort Atkinson physician, discussed school health program and childhood diseases, March 16 at Caswell Elementary School Parent-Teacher Association meeting, Fort Atkinson.

Dr. John M. Schroeder, Madison, at the annual Cancer Crusade kickoff meeting of Adams County unit of the American Cancer Society, March 24 at Adams.

Dr. W. E. Scheunemann, West Bend ophthalmologist, March 15 at an Inter-School Health Council meeting in West Bend, described criteria in evaluating visual disorders, differences in visual defects, value of plastic lenses for children's safety, emotional aspects in visual problems, and need for proper interpretation and evaluation in each child's vision screening study.

Dr. Ralph E. Tomkiewicz, Racine psychiatrist, stressed importance of research in talk on "Emotional Problems Involved with the Family of a Retardate," March 9 at meeting of Kenosha County Association for Retarded Children. On March 18, Doctor Tomkiewicz explained the operation of the recently opened psychiatric unit at St. Catherine's Hospital, Kenosha, in a talk before the hospital's auxiliary. Doctor Tomkiewicz is in charge of the 17-bed unit.

Dr. George E. Collentine, Jr., clinical director of St. Mary's Hospital Burn Center, Milwaukee, stressed prevention while describing the background of the burn center and treatment of patients, in talk before La Crosse Industrial Safety Council March 29 at La Crosse.

Dr. Hugh F. DeMorest, Jr., Menasha, discussed topic, "How to Keep Your Husband Alive," at the March meeting of Neenah–Menasha Visiting Nurses Association Auxiliary in Neenah.

continued next column

PHYSICIAN NEWS *continued*

Dr. Mueller Adviser

Dr. Gilbert F. Mueller, Jr., Appleton, was appointed by the Outagamie County Medical Society in March to act as medical adviser for the newly organized Greater Appleton Area Safety Council.

Dr. Horsley at Ringside

Dr. D. B. Horsley, who was on the boxing team while studying at the University of Virginia, serves as examining physician for the Golden Gloves boxing matches in Kenosha.

Dr. Apfelbach Certified

Dr. G. L. Apfelbach of the Janesville Medical Center has been notified that he has been certified by the American Board of Urology.

Dr. Kincaid Sounds Warning

Dr. C. K. Kincaid, Madison city health director, told a meeting of the Madison Board of Health on March 24 that unless Madison residents are vaccinated, they will be faced with a red measles epidemic next winter.

Dr. Gehin at ACP Meeting

Dr. F. E. Gehin, Stevens Point, attended the 50th annual meeting of the American College of Physicians March 22–26 in Chicago.

Dr. Barr at Las Vegas Symposium

Dr. and Mrs. *A. H. Barr*, Port Washington, attended the National Medicolegal Symposium March 11–13 in Las Vegas, Nev.

PHYSICIANS SPEAK continued

Dr. S. F. Morgan, associate clinical professor of pediatrics at Marquette University School of Medicine, as a panel speaker at a nurses' workshop on "Nursing Care of Children with Heart Disease," March 25 at the University's College of Nursing, said he believes some school athletic programs pose a threat to pupils' health.

Dr. R. C. Frank, Eau Claire radiologist, told Chippewa Falls Rotarians on March 23 that smokers who rely on filters, pipes, and cigars as the means of escaping lung cancer are deluding themselves.

Dr. George A. Hellmuth, associate professor of occupational and environmental medicine at Marquette University School of Medicine, reported results of a study of state employment practices at a cardiac-in-industry conference held April 5 in Wauwatosa. About 55 per cent of Wisconsin industries refuse job applicants if they have heart conditions, Doctor Hellmuth said.

Dr. Mueller at Quisling Clinic

The Quisling Clinic in Madison in March announced the association of *Dr. Gustave C. E. Mueller* in the department of thoracic, vascular, and general surgery. A cum laude graduate of Harvard Medical School, Boston, Doctor Mueller from July 1957 to July 1964 took a surgical internship and residency at Massachusetts General Hospital. During this period, he was one of the team of vascular surgeons performing the second successful reattachment of a completely amputated arm. His background also includes research and teaching at Edinburgh, Scotland, and six months in the cardiac surgery and thoracic unit of Frenchay Hospital and Bristol Royal Infirmary, Bristol, England.

Dr. Troup at Haiti Clinic

Dr. and Mrs. *W. J. Troup*, De Pere, were to return about May 1 from a month spent serving at a clinic at Port de Paix, Haiti. Doctor Troup is an associate of the Green Bay Clinic. He and his wife went to Haiti as part of a project of an association of eye, ear, nose and throat specialists based in Chicago.

Participate in Symposium

Wisconsin physicians taking part in the program for the Symposium on Anxiety held April 14 in Eau Claire included *Dr. Carl Fellner*, Department of Psychiatry, University of Wisconsin Medical

NARCOTICS REGISTRATION DUE BEFORE JULY 1

Every physician who distributes, dispenses, gives away, or administers narcotic drugs to patients must register and pay a tax of $1.00 on or before July 1.

Registration is accomplished through the Director of Internal Revenue, Milwaukee, Wis. 53201. Direct any correspondence to that address.

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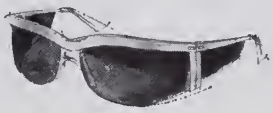

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School, Madison, who spoke on the subject, "Drug Treatment of Anxiety;" *Dr. B. H. Glover*, also from the U. W. Department of Psychiatry, who served as moderator for case presentations, *Illustrative Examples of Systemic Involvement*, with the following participants: *Dr. Glenn G. Giffen*, Eau Claire (cardiovascular); *Dr. William Wright*, Mondovi (idiopathic fluid retention); and *Dr. L. A. Raymond*, Eau Claire (respiratory).

Richard Sternbach, Ph.D., assistant professor of psychiatry at the University, spoke on the topic, "Principles of Psychophysiological Disorders."

The symposium, general theme of which was "The Anxious Patient—the Physician's Responsibility," was approved by the Commission on Scientific Medicine of the State Medical Society of Wisconsin, and presented in cooperation with the Wisconsin Psychiatric Institute, the State Department of Public Welfare, Division of Mental Hygiene, and the Northwest Psychiatric Clinic.

WISCONSIN STATE MEDICAL GOLF ASSOCIATION PLANS JUNE 28 MEET AT MILWAUKEE'S TUCKAWAY

The Spring Tournament of the Wisconsin State Medical Golf Association will be held at the Tuckaway Country Club, 3445 W. Edgerton av., on Monday, June 28. Tee off time will begin at 10 a.m. Lunch will be available beginning at 11 a.m.

Dr. John T. Garren of Kenosha will be defending his first low gross score of 74, shot at the 1964 tournament. *Dr. W. H. Williamson* of Racine was awarded the second lowest gross and lowest net awards last year.

Prizes and trophies will be awarded to members receiving the lowest net score, ball closest to the pin, and longest drive.

Physician golfers who are not members of WSMGA are invited to make tournament reservations and/or application for membership. Lifetime membership in the WSMGA is only $5.

Reservations for dinner and golf at the June 28 tournament is $16 per person; golf only, $8; and dinner only, $8. Reservations and applications for membership should be sent to Mr. A. H. Luthmers, Executive Secretary, Wisconsin State Medical Golf Association, 756 N. Milwaukee St., Milwaukee, Wis. 53202.

The Association's Fall Tournament and annual meeting will be held at the Janesville Country Club on Wednesday, September 15.

The 1965 officers of the WSMGA are: president, *Dr. William Madden* of Racine; vice-president, *Dr. Norman Erdmann* of Manitowoc; secretary-treasurer, *Dr. David Carlson* of Milwaukee; and directors, *Drs. Sture Johnson* of Madison and *Robert Flood* of Milwaukee.

Oconto Expecting Two More Doctors

Drs. John Honish and Robert Heinen, interns at La Crosse's Gundersen Clinic, have announced plans to begin medical practice in Oconto, where *Dr. F. E. Zantow* has been the sole physician since the death of Dr. H. A. Aageson and the departure of two other doctors for military service.

Doctor Honish said he would move to Oconto in July and take over Doctor Aageson's clinic. Doctor Heinen announced that he would take a year's surgical residence at the Gundersen Clinic before joining Doctor Honish in Oconto in the summer of 1966.

Dr. Fitzsimmons at Siren

Dr. James R. Fitzsimmons began medical practice at the Siren Clinic April 7. A graduate of the University of Wisconsin Medical School, Doctor Fitzsimmons interned at Stamford Hospital, Stamford, Conn., spent four years in general practice at Taunton, Mass., and six years in pharmaceutical research in the East before returning to general practice in Milwaukee this past year.

Dr. Kline Leads Symposium

Dr. Carl L. Kline, medical director of Marathon County Guidance Center and director of the Pediatric Reading Clinic at Wausau, served as chairman of a symposium on reading disabilities at the annual meeting of the American Orthopsychiatric Association March 16–21 in New York.

Dr. Rosekrans Praised

Dr. Sarah D. Rosekrans, Neillsville physician and surgeon, was lauded in a column entitled "Area Women" April 2 in the EAU CLAIRE LEADER. In a biographical sketch emphasizing her ability in the world of music as well as in medicine and other fields, the paper called Doctor Rosekrans "probably the most publicized and most widely known woman residing within the limits of Clark County."

Dr. Clothier Memorialized

In memory of the late Dr. Walter J. K. Clothier, the Waukesha Lions Club on April 1 presented a check for $2,500 to Waukesha Memorial Hospital for a new receptionist's office. The office, which will be in the new hospital addition, will be used by *Dr. H. A. Gantz*, president of the hospital medical staff.

Dr. Theiler Honored as Man of Year

Dr. A. C. Theiler, a Kiel physician since 1954, was presented the "Man-of-the-Year" award by fellow members of the Kiel Kiwanis Club March 30 at a dinner meeting in Kiel. One of several speakers who lauded Doctor Theiler was *Dr. H. N. Heinz* of

Sheboygan, who said he had never known anyone quite as civic-minded as Doctor Theiler. Another Kiel physician, *Dr. D. F. Nauth*, is a previous winner of the award.

Dr. Kozina Credits Fetal Transfusions

Dr. Thomas J. Kozina, Milwaukee, credited three blood transfusions administered to a fetus during the three months prior to birth with saving the life of a boy born April 2 at St. Luke's Hospital, Milwaukee. The birth was the first in a private Milwaukee hospital in which the fetal transfusion procedure has been successfully used, Doctor Kozina said. The only other live birth in the Milwaukee

Dr. Dibble in Demand as Speaker

Since his retun late in 1963 from service as a medical missionary in Africa, *Dr. J. Birney Dibble*, Eau Claire physician and surgeon, has addressed more than 50 groups—medical societies, hospital staffs, nurses' organizations, service clubs, churches, women's organizations, and a group of students at the University of Illinois College of Medicine, Chicago.

Doctor Dibble, whose wife (a registered nurse), and two children accompanied him to Africa, spent 15 months as physician and surgeon in a 100-bed mission hospital in Kiomboy, Tanganyika, Africa, a village of a couple hundred residents. Along with the surgery he performed on native patients, one of his first projects was organizing the hospital's surgical department.

Dr. J. B. Dibble

Through his talks, which are actually lectures illustrated with movies, slides, and tape recordings, Doctor Dibble has raised more than $5,000, all of which has been used to buy much needed equipment for the hospital. Interest in his work continues, and he is "booked up" into October. This summer, a book by Doctor Dibble will be published dealing with his experiences in Africa.

Born in Madras, India, where his father, a Methodist minister, was serving as a missionary, Doctor Dibble received his medical education at the University of Illinois College of Medicine, Chicago, and served both his internship and residency at Chicago's Cook County Hospital. He had been in Eau Claire for five years when he interrupted his practice to go to Africa. During the war in Korea he served a year and a half with a Marine combat group and was awarded the Bronze Star and Commendation medal.

IN CELEBRATION of his 89th birthday anniversary, which also marked his retirement from practice, Dr. Louis E. Frazen, Sr., Racine, was honored at a birthday dinner at the Racine Country Club, which once was the site of his father's dairy farm. Host and hostess for the party were the doctor's son and daughter-in-law, Dr. and Mrs. Louis E. Fazen, Jr., Racine. Doctor Fazen's other four children were also present.

Dr. Fazen Retires

Dr. Louis E. Fazen, Sr., Racine, chose his 89th birthday anniversary March 11 to retire from active practice after 65 years as a physician and surgeon. A longtime colleague and friend, *Dr. John H. Hogan*, Racine, in a eulogy of Doctor Fazen called him "the first recognized general surgeon in Racine . . . considered by many . . . as the father of surgery in Southeastern Wisconsin."

A Racine native and one of 11 children of immigrant parents, Doctor Fazen qualified in the Illinois State Medical Examinations in 1899 and practiced in Chicago during his final year at Northwestern University Medical School. He began his Racine practice in June 1900. The long hours of a doctor were familiar to him for he had spent his early years working on his father's dairy farm. He would milk the herd at 5 a.m. and deliver the milk before 7 in order to be on time for school. After school and on weekends and holidays he worked in the Giesler Drug Store. In 1894, at the age of 18, he became a registered pharmacist. In 1906, he was one of eight physicians who founded the Holmberg–Wichern Drug Company, which became the Red Cross Drug Company in 1916.

Doctor Fazen served as chief of staff and chief of surgery at St. Mary's Hospital, Racine, from 1915 to 1940, when he was given emeritus status in both. In tribute to his service, bronze plaques have been on display since 1961 at the hospital and since 1960 at St. Catherine's Convent. Doctor Fazen was president of the Racine County Medical Society for several terms, and in 1914 he became a founder member of the Wisconsin Surgical Society. He is also a fellow of the American College of Surgeons.

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The portially demolished hospitol at Fort Crawford as shown in this photograph of 1894.

THE MUSEUM OF MEDICAL PROGRESS and STOVALL HALL OF HEALTH

Few fields can rival the progress made in medical science during the past few centuries. Highlights of this fascinating story are shown in exhibits and displays at the Museum of Medical Progress and Stovall Hall of Health.

PRAIRIE DU CHIEN

Prairie du Chien was the crossroad of the Midwestern frontier in the late eighteenth and early nineteenth centuries. It was a major fur trading center and the site of a succession of forts built by the French, British and Americans.

WILLIAM BEAUMONT, M.D.

It was in connection with the early Prairie du Chien forts that Dr. William Beaumont, a military surgeon, completed his pioneering experiments in the physiology of digestion.

The story of Doctor Beaumont and his work with Alexis St. Martin, "the man with a hole in his stomach," is one of many depicted at the museum. Doctor Beaumont, in the 1830's, was stationed at the military hospital of the Second Fort Crawford, which has been restored as one of the three buildings at the Museum of Medical Progress.

MILITARY HOSPITAL

The reconstructed military hospital of the Second Fort Crawford has exhibits depicting the Indian medicine man, the military fort physician, the family doctor from "horse and buggy" days to the present, great events in the development of surgery, and physicians' offices of 1850 and 1900. Medical Still Lifes painted by Aaron Bohrod, artist-in-residence at the University of Wisconsin are also on display.

STOVALL HALL OF HEALTH

Featured in this large hall are displays on the evolution of diagnosis, health fads and fallacies, dentistry, and a variety of other health subjects. The Stovall Hall of Health periodically features outstanding exhibits on such topics as space medicine, the heart, nutrition, birth, and others, obtained on loan for special showings.

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Gundersen Visiting Professor at UW

Dr. Rudolf J. Noer, professor and chairman of the department of surgery, University of Louisville, is spending the week of May 16 at the University of Wisconsin Medical Center as the Adolf Gundersen Visiting Professor of Surgery.

While visiting Wisconsin, Dr. Noer will lecture to staff, faculty and students, and will conduct rounds and participate in discussions with students and house staff, according to *Dr. Robert C. Hickey,* professor and chairman of surgery at Wisconsin. Doctor Noer's particular area of interest is intestinal obstruction, intestinal circulation, and diverticular disease of the colon.

He received his A.B. degree from Wisconsin in 1924 and his M.D. from Pennsylvania in 1927, served a two-year internship in Philadelphia, and returned to Wisconsin in 1929 to spend three years in general practice at Wabeno. In 1932, he returned to the University of Wisconsin for a surgical residency.

Doctor Noer's visit is under the auspices of the Adolf Gundersen Foundation of La Crosse, which annually sponsors a visiting professor of surgery.

Helen Halverson Professor

Dr. Joseph P. Evans, professor and director of neurological surgery, University of Chicago, was Helen Halverson Visiting Professor of Neurological Surgery at the University of Wisconsin from March 30 to April 2. The visiting professorship is provided by Mr. Harold F. Halverson of Beloit and family in memory of Mrs. Helen Halverson.

Dr. Bailey Retiring

After 62 years of practicing in Fennimore, *Dr. M. A. Bailey* has announced his retirement, effective June 30. The 86-year-old dean of Fennimore physicians will close his office on that date and completely retire as an M.D., including his staff appointments at the Lancaster and Boscobel hospitals.

Granted Fellowship in Pediatrics

Dr. James E. Gutenberger, Sheboygan, is one of 15 physicians whom the Wyeth Fund for Post-

Wisconsin Youths Among 28 Recipients Of SK&F Foreign Fellowships

Two Wisconsin men and a Washington youth studying at Marquette University are among the 28 junior and senior U.S. medical students who have been awarded Smith Kline & French foreign fellowships, the Association of American Medical Colleges has announced.

The three recipients of the fellowships, which will enable them to obtain supervised medical experience in relatively underdeveloped areas of the world, are Robert Leslie McRoberts, Sheboygan, junior at Yale University School of Medicine and son of *Dr.* and Mrs. *J. W. McRoberts* of Sheboygan, who will go to the Methodist Mission Hospital at Ganta, Liberia; Paul Rudolph Miller, Wenatchee, Wash., junior at Marquette University School of Medicine, Milwaukee, who is going to Driefontein Sanatorium, Gwelo, Rhodesia, and Gaylan Lee Rockswold, Madison, junior at the University of Minnesota Medical School, whose wife, Mary, will accompany him to Likwenu Hospital, Likwenu, Malawi. Mrs. Rockswold is one of seven wives who will accompany their husbands because they qualify by virtue of their training as medical students, nurses, or technicians.

The students, selected by a committee of six U.S. medical educators, spend at least 10 weeks with their foreign sponsors. The amount of each award varies, depending on individual requirements.

The Fellowships are made possible by a grant from Smith Kline & French Laboratories. With the current selection, the Association, during six years, has awarded a total of 180 fellowships for work and study in 42 countries of Africa, Asia, and Latin America. Primary objective is to provide students an opportunity to benefit from unusual clinical experiences and familiarize themselves with different medical, cultural, and social problems. They will be stationed in mission hospitals and outpost medical facilities.

Photo by Dave Lindberg, Marshfield Clinic

THE SAUTTER OXYGENATOR, pictured in the foreground, was exchanged for the U.S. Army's heart pump (the box-like unit in the background) on March 11 at the Marshfield Clinic. The pump, for use in open heart surgery, was developed at Walter Reed Medical Research Center and at the Harry Diamond Laboratories in Washington, D.C. Developer of the oxygenator is *Dr. Richard D. Sautter,* cardiovascular surgeon at the Clinic, who is pictured at right. At the left is Capt. Martin Dalton, cardiovascular surgeon at the Walter Reed Center, and at the center is Sam Wagner, engineer and administrative officer at Harry Diamond Laboratories. The Walter Reed Center and Clinic Foundation are exploring the possibilities of using the instruments as a combined device for use in certain types of heart attacks.

graduate Medical Education has granted two-year residency fellowships in pediatrics, starting July 1. He will study at the University of Wisconsin Medical School, Madison.

Three Groups Hear Dr. Shahrokh

Dr. D. K. Shahrokh

Dr. Darius K. Shahrokh of Fond du Lac Clinic, Fond du Lac, presented a lecture on "Deafness, Its Modern Concept and Treatment" before three different groups in February and March. He addressed the February meeting of the third district of the Wisconsin Society of Roentgenologic Technicians, the March meeting of the Fond du Lac Medical and Dental Assistants, and the biennial convention of the Wisconsin Student Nurses Association March 20 in Fond du Lac. Discussing different types of deafness, Doctor Shahrokh stressed otosclerosis and serous otitis media.

Bowling Tournament Results at Marshfield

A somewhat small but enthusiastic group of bowlers convened in Marshfield March 13 and 14 for the State Medical Bowling Tournament at the Janes Lanes. Dr. F. John Gouze, chairman, reported the following winners of the handicap event:

MEN'S SINGLES: Dr. C. P. Giesen, Tomah, score 594; second, Dr. F. W. Fletcher, Marshfield, 593; third, Dr. C. B. Koch, New Lisbon, 590. MEN'S DOUBLES: Dr. H. W. Carey, Lancaster, and Dr. J. J. Mulvaney, Marshfield, total 1186; second, Doctor Koch and Doctor Giesen, 1177; third, Dr. G. L. River, Marshfield, and Dr. T. F. Nikolai, Marshfield, 1142.

The men's team event was won by the Marshfield Clinic. The team was composed of Drs. C. A. Vedder, D. P. Pederson, T. G. Olsen, F. J. Gouze, and T. J. Rice. Total score was 2800. The men's all events was won by Doctor Nikolai with the composite score of 1958; second, Doctor Koch, 1754; and Dr. A. Adair, 1716.

LADIES' SINGLES: Mrs. Koch, total 561; second, Mrs. Gouze, 540; third, Mrs. R. F. Lewis, Marshfield, 531. LADIES' DOUBLES: Mrs. Carey and Mrs. Lewis, score 1044; second, Mrs. Gouze, and Mrs. Mulvaney, 994; third, Mrs. Giesen and Mrs. Koch, 980. The ladies team consisted of Mrs. T. G. Olsen, Mrs. Lewis, Mrs. Carey, and Miss Ulrich. Their total was 2008.

BASIC SCIENCE PROFESSOR IS FIRST SCIENTIFIC FELLOW OF STATE MEDICAL SOCIETY

Alvin Berman, associate professor of Anatomy at the University of Wisconsin, was elected to the status of Scientific Fellow of the State Medical Society at the March meeting of the Council.

Doctor Berman is the first scientist to apply for and receive status in the new category, which was created last May by the House of Delegates of the State Medical Society at its annual meeting in Milwaukee.

The status was created to promote communication and contact between the teacher of the basic sciences and the practicing physician. It entitles Doctor Berman to attend all scientific sessions of the Medical Society and to receive the WISCONSIN MEDICAL JOURNAL.

Doctor Berman received his Ph.D. in neurophysiology from Johns Hopkins in 1957 and has been involved in research and teaching in neuroanatomy at the University. He is also an affiliate member of the American Medical Association.

CREDIT DUE

In the January Blue Book issue of the *Wisconsin Medical Journal* we omitted credit to the Legislative Reference Library for supplying pictures and text concerning the members of the 1964–1965 Wisconsin Legislature.

OUR THANKS

GRADUATING MEDICAL ASSISTANTS TO BE AVAILABLE IN JUNE

On June 8 the Madison Vocational, Technical and Adult School will graduate 38 medical assistants and 14 medical secretaries. Graduates of these two programs are well-versed in medical technology, medical ethics, medical legal practices and medical record keeping. The secretaries are excellent typists and specialize in medical shorthand and insurance processing. The assistants are medical office aides trained in assisting skills, laboratory techniques, and electrocardiography. In addition to two semesters of theory and practice all 52 graduates have had three weeks field experience in a physician's office, clinic and/or hospital record room. Contact Mrs. June Tyler, Teacher-Coordinator of the Medical Assistants program for further information or employment of these graduates. Telephone 255–4541.

MIXED DOUBLES: Doctor and Mrs. Koch, total 1126; second, Doctor Rice and Mrs. A. M. Kinkella, Marshfield, 1121; third, Doctor and Mrs. Fletcher, 1115.

A dinner-dance was held at the Charles Hotel on Saturday night at which Saturday's trophies were awarded and door prizes were given out. About 50 couples attended the dance. Bowling resumed on Sunday.

Doctor Gouze and other participants have expressed the hope that similar bowling tournaments can be held in the future, possibly as an annual event at other locations in the state, perhaps becoming one of THE events of the year.

Health Fads and Fallacies Conference Attracts 200 at Green Bay

A need for increased efforts in health education to combat fraudulent health practitioners, practices, and materials was stressed by speakers at the Wisconsin Conference on Health Fads and Fallacies April 8 in Green Bay.

Sponsored by the State Medical Society of Wisconsin and held at Brown County Veterans Memorial Arena, the conference attracted approximately 200 people and featured seven speakers of prominence in various fields where health frauds are prevalent.

At a pre-conference dinner on April 7, John Guy Miller, minority staff director for the U.S. Senate Committee on Aging, listed several reasons why people are prone to seek fraudulent health care. There are powerfully well organized groups that are determined to cloud the health issues involved, he said.

Miller cited the recommendations made in the 1964 U.S. Senate Committee on Aging report. Of the 12 listed at the report's conclusion, eight related to health frauds perpetrated against the aging. Among them were recommendations to create pre-market testing facilities through the FDA; to create a federal anti-quackery bureau, and a postal fraud statute that would erase the need to prove "intent to defraud."

Citing the conference as a major means of combatting quackery, Miller said, "I commend the people who arranged this conference, because when life is at stake, law becomes secondary. It is knowledge through education that will help put an end to quackery."

Miller stated the same belief as speaker at the conference the following day. While statutes to protect all consumers could be enacted, he said, they would place undue hardships on legitimate manufacturers.

Describing his experience as an osteoarthritis victim, John B. Torinus, APPLETON POST-CRESCENT editor and vice-president of the Arthritis Foundation of Wisconsin, outlined the many types of cures he tried before finding the particular regimen, based on medical advice, that allowed him to live with his disease.

At the afternoon sessions, *Dr. Robert G. Zach*, Monroe, asked members of the audience to make up their own minds as to which was the scientific health practitioner, the medical doctor or the chiropractor. Using examples of literature and correspondence and demonstrations with machines that have been confiscated by the FDA, Doctor Zach asked that each person present carefully evaluate the evidence.

Referring to the use of the title "Doctor," he observed that a bill to allow chiropractors to use the title was receiving favorable consideration in the Wisconsin Assembly.

Glenn R. Knotts, Chicago, director of the office of advertising evaluation of the American Medical Association, quoted a recent survey of 18,000 high school students in which it was proven that those students who had received accurate and scientifically based health information were less likely to become the victims of the useless items and services offered by nonmedical practitioners.

"The American Cancer Society isn't so worried about the waste of dollars or the false hopes the quack sells, but we are worried about the lives that are lost," declared Francis J. Wilcox, Eau Claire, chairman of the board of directors of the American Cancer Society, Inc., in his talk, "Unproven Cancer 'Cures' Cost Lives." "One out of three cancer victims today are saved but one out of two could be saved if detected early enough."

Miss Joan Reid, Madison, cooperative extension nutrition specialist of the Department of Foods and Nutrition, School of Home Economics, University of Wisconsin, spoke on nutrition nonsense. Stressing the need for proper education, Miss Reid pointed out that when the fundamentals of nutrition are properly taught, there is less chance of the "food quack" making inroads on the budget.

John Guill, Jr., director of the Chicago FDA district office, closed the conference with a review of the functions of the Food and Drug Administration. Augmenting his speech with a series of colored slides, he outlined the areas of concern with public health that are covered by the FDA.

Dr. Jack A. Killins, Green Bay, official host for the conference, moderated the morning discussions. *Dr. C. F. Broderick*, Wisconsin Dells, last year's conference chairman, acted as moderator for the afternoon sessions.

Dr. W. P. Curran, Antigo, State Medical Society president, gave the official greeting, welcoming conferees and thanking the citizens and physicians of Green Bay for the warm welcome afforded all those concerned with the conference.

OBITUARIES

Dr. William J. Bleckwenn, 69, renowned neuropsychiatrist, died Jan. 6, 1965, at Winter Haven, Fla., where he had lived since 1957.

Born in Astoria, Long Island, N. Y., he held an M.D. from Columbia University. His internship was served at Bellevue Hospital, New York, and his residency at Wisconsin Psychiatric Institute.

Doctor Bleckwenn was a veteran of both world wars, serving in World War II as colonel in command of the 135th Medical Regiment under Gen. Douglas MacArthur. He was awarded the Presidential Citation for establishing the first psychiatric hospital in World War II, and the Legion of Merit with Oakleaf Cluster for organizing the largest World War II neuropsychiatric hospital, at Camp Custer, Mich.

Following his discharge in 1946, Doctor Bleckwenn returned to the University of Wisconsin, where he had been professor of neuropsychiatry from 1935 until his entry into the service in December 1940. From 1948 until his retirement in 1954, he was chairman of the department of neuropsychiatry. He also served at one time as chairman of the medical advisory board of veterans affairs and consultant in neuropsychiatry to the surgeon general of the U.S. Army.

Among the many organizations of which he was a member were the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Psychiatric Association.

Known as the discoverer of sodium amytal, Doctor Bleckwenn also helped develop the drugs picrotoxin and tryparsamide.

He is survived by his widow, Marion; a daughter, Mrs. Jane B. Birkenmeier, Mexico City, and a son, A. Theodore, Madison.

Dr. Erwin L. Rice, Milwaukee, who had been on the staff at the Veterans Administration Hospital at Wood for the past eight years, died Jan. 7, 1965. He was 58.

A native of Milwaukee, Doctor Rice received his medical degree in 1931 from Marquette University School of Medicine in that city, and interned at Milwaukee Maternity and General Hospital. He practiced in Milwaukee for 26 years.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Claire, and a daughter.

Dr. Joseph H. Weisberg, prominent Superior physician and surgeon, died Jan. 8, 1965, at the age of 63.

A native of Milwaukee, he received his medical degree from Marquette University School of Medicine in that city. He interned at St. Mary's Hospital, Superior, and had practiced in Superior throughout his entire medical career. From 1926 to 1937, Doctor Weisberg was city school physician, and he had also served as chief medical director of the Douglas County Civil Defense. He had recently been appointed chief of staff at St. Mary's Hospital, and had previously served in the same capacity at St. Joseph's Hospital, Superior.

He was a member of the Douglas County Mental Health Association, the Douglas County Medical Society, State Medical Society of Wisconsin, American Medical Association, American Diabetes Association, American Academy of General Practice, and the Interurban Academy of Medicine, of which he was a past president.

Survivors include his widow, Aneta; a son, Dr. Paul S., Washington, D. C.; a daughter, Mrs. Richard Marcus, Minneapolis.

Dr. Edwin H. Federman, who estimated that he delivered about 90 per cent of the babies born in the Montello area in the 50 years before his retirement in 1949, died Jan. 10, 1965, at the age of 83.

A native of Milwaukee and a 1903 graduate of Milwaukee Medical College, now Marquette University School of Medicine, Doctor Federman served both his internship and his residency at Milwaukee County Hospital. After practicing briefly in Pine River and Plainfield, he located in Montello in 1911. His practice there was interrupted by military service in World War I. From 1943 until 1948 Doctor Federman practiced at Horicon.

He was a member of the Columbia–Marquette–Adams County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and numerous other organizations. His membership in the State Medical Society extended back more than 50 years.

Survivors include his widow, Erma; a daughter, Mrs. Frank Dellert, Bloomfield, Conn., and two grandchildren. Another daughter, Mrs. Eleanor Krueger, preceded Doctor Federman in death.

Dr. Joseph P. McMahon, prominent Milwaukee physician who was Marquette University's first professor of obstetrics in 1913, died Jan. 23, 1965. He was 85 years old.

Doctor McMahon was managing editor of the *Wisconsin Medical Journal* from 1910 to 1923. Not long before his death, he assigned his estate, valued at $203,205, to Marquette to create a chair in obstetrics and gynecology.

While working for his medical degree from the Wisconsin College of Physicians and Surgeons (now Marquette University School of Medicine), Doctor McMahon served as an extern at Waukesha Springs Sanitarium, and an intern at St. Joseph's Hospital, Milwaukee. Immediately following his graduation in 1903, he located in Union Grove, where he was physician to the Racine County Hospital and Home for Indigents for two years. Graduate work followed in Vienna, Austria, and the New York Post–Graduate Medical School and New York Lying-In Hospital.

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In 1907 Doctor McMahon relocated in Milwaukee where his practice was principally in obstetrics and gynecology, and later on radium therapy. He was a member of the obstetrics and gynecology staffs of the following hospitals: Trinity, Milwaukee Maternity, Misericordia Maternity, Milwaukee County, St. Mary's, Johnston Emergency, and Columbia, and chief of the department of obstetrics and gynecology and member of the consulting staff and at the outset chief of the Cancer Clinic, Milwaukee County Dispensary. In addition to his professorship at Marquette, he was a special lecturer on the cancer problem and radium therapy for the University of Wisconsin Extension Division.

Doctor McMahon served as staff physician in the Office of the Secretary of War, Civilian Medical Division, Washington, D. C., from Oct. 17, 1942, until Sept. 1, 1951, when he was appointed chief medical officer, Department of Defense, Civilian Employees' Health Service, and served to Nov. 30, 1957.

He was a life member and past president of the Milwaukee Academy of Medicine, an honorary member and past president of the Marquette University Medical Alumni Association, and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, American Academy of Medicine, Wisconsin Surgical Association, Milwaukee Association of Obstetricians and Gynecologists, and numerous other organizations. He was also the author of many essays published in medical and medico-sociologic journals.

Surviving is a brother, Dr. Francis McMahon, Milwaukee surgeon.

Dr. William G. Meier, a Sheboygan eye, ear, nose, and throat specialist since 1931, died Jan. 28, 1965, at the age of 58 years.

He was born in Escanaba, Mich., and held a degree in medicine from the University of Michigan at Ann Arbor, where he was honored with membership in Phi Beta Kappa. His internship was served at Evanston Hospital, Evanston, Ill., and his residency at Illinois Eye and Ear Infirmary, Chicago.

A member of the medical staffs of St. Nicholas and Sheboygan Memorial Hospitals, Sheboygan, Doctor Meier belonged to the Sheboygan County Medical Society, the State Medical Society of Wisconsin, American Medical Association, Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Milwaukee Eye, Ear, Nose and Throat Society and Pan American Eye, Ear, Nose, and Throat Society.

Surviving are his widow, Eunice; a son, William G., III, Waukegan, Ill.; a daughter, Mrs. Donald Barkony, Cleveland Heights, O.

Dr. Samuel Rosenthal, Milwaukee pathologist and a faculty member for more than 25 years of the Marquette University School of Medicine, Milwaukee, died Feb. 6, 1965, at the age of 58.

A 1931 graduate of Marquette University School of Medicine, Doctor Rosenthal was a former chief of staff at St. Joseph's Hospital, Milwaukee, where he had played a major role in raising money for a $10 million wing.

He was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians and Surgeons, and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Ruth.

Dr. Leo W. Peterson, 69, retired Sun Prairie physician, died Feb. 9, 1965.

A 1923 graduate of Rush Medical College, Chicago, Doctor Peterson interned at Madison General Hospital, Madison, and began his Sun Prairie practice in 1924. He retired five years ago.

He had a record of service with the infantry in World War I and as a colonel in World War II. His six-year period of service in the second world war included 21 months as commander of the 18th Station Hospital in the Pacific Theater and 10 months as post surgeon in the same theater. His decorations included the Army Commendation Ribbon and Presidential Citation.

He was a fellow of the American College of Surgeons, and a member of the American Academy of General Practice, the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Mary.

Dr. Ernst Albert Pohle of Madison, German-born former chairman of the University of Wisconsin Department of Radiology, died Feb. 10, 1965, at the age of 69. A pioneer in the use of radiation for medical therapy, he had been retired from the University faculty since 1961.

Doctor Pohle received his medical degree in 1921 from the University of Frankfurt on Main and interned at City Hospital in his native city of Wiesbaden, Germany. He came to this country in 1923 to be assistant professor of roentgenology at Mt. Sinai Hospital, Cleveland, O. In 1925 he began study at the University of Michigan, and obtained a Ph.D. in biophysics from that school in 1928.

In the fall of that year he came to the University of Wisconsin to become its first professor of radiology and to head the new Department of Radiology at the Medical School. Soon after, he established Madison as one of the first centers for radiation therapy and the University as one of the few institutions producing radon "seeds" for this therapy.

In 1951, Doctor Pohle was instrumental in setting up at the University a million-volt x-ray machine which has proven very useful in cancer therapy.

A prolific writer on medical subjects, chiefly roentgenology, Doctor Pohle was a diplomate on the American Board of Radiology, a fellow of the

continued on page 43

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 31, 1965

NEW MEMBERS

Louis C. Bernhardt, 38 Belmont Road, Madison.
Frederick H. Bronson, 310 West Conant Street, Portage.
Jeremy R. Green, 205 East Walnut Street, Green Bay.
Charles D. Grose, 310 West Conant Street, Portage.
Jack R. Inyart, Osceola.
Michael A. Jacobi, 2300 Western Avenue, Manitowoc.
Joseph S. Pennepacker, 556 North Washington Street, Janesville.
George W. Wirtanen, 13-D University Houses, Madison 53705.

CHANGES OF ADDRESS

James C. Allen, Department of Ophthalmology, University Hospitals, Madison 53706.
Lester J. Bayer, 1029 East Main Street, Merrill.
V. M. Bernhard, 4122 Gairloch, Houston, Tex. 77025.
J. F. Bigalow, 712 East Second Street, Merrill.
James W. Bookhammer, Wauwatosa, to 400 West Silver Spring, Milwaukee.
William E. Braun, 712 East Second Street, Merrill.
Dwight H. Brown, Milwaukee, to Route 2, Box 295A, Pewaukee.
Myra E. Burke, 2242 Eton Ridge, Madison 53705.
Anthony T. Buscaglia, 6001 West Center Street, Milwaukee.
Alfons Busza, Elm Grove, to 3849 Spring Valley Road, Mountain Brook, Ala.
W. W. Chandler, 506 East Longview Drive, Appleton 54914.
B. W. Claypool, Jr., 424 East Longview Street, Appleton 54914.
E. D. Deocampo, Racine, to 27714 Roan Street, Warren, Mich. 48089.
Manfred Effenhauser, Winneconne, to Box 5, Lake Mills 53551.
Stephan Epstein, Marshfield, to 2705 Marshall Court, Madison.
Albert L. Fisher, Box 806, La Crosse 54602.
C. A. Fosmark, 2453 Atwood Avenue, Madison 53704.
E. C. Glenn, Wisconsin Rapids, to Medical Arts Building, Port Edwards 54494.
Larry O. Goldbeck, San Francisco, Calif., to USAF Hospital, Travis AFB, Calif.
R. H. Graves, Campbellsport, to 5017 Starker Avenue, Madison 53716.
Robert E. Handte, Menasha, to 2405 North 64th Street, Wauwatosa 53213.
J. S. Hirschboeck, 615 North 11th Street, Milwaukee 53233.
John H. Huston, Wauwatosa, to 7635 West Oklahoma Avenue, Milwaukee.
Clarence W. Jordahl, 2669 North Terrace Avenue, Milwaukee.
William F. Kennedy, 451 East Peckham, Neenah 54956.
Milton G. Klumb, 2708 North 84th Street, Milwaukee 53222.
J. D. Millenbah, 107 North Scott, Merrill.
D. E. Mings, Box 253, Monroe.
R. A. Powell, 8011–14th Avenue, Kenosha 53140.
Erling O. Ravn, Jr., 716 East Second Street, Merrill.
Erling O. Ravn, Sr., 716 East Second Street, Merrill.
Richard J. Rogers, 11½ North Wisconsin Street, Elkhorn.
Theodore Rowan, 207 South University Avenue, Beaver Dam.
James H. Schultz, P.O. Box 379, West Bend.
W. R. Schwartz, Wauwatosa, to 2212 West State Street, Milwaukee 53233.
Gilbert H. Stannard, 1425 Gunnell Lane, Manitowoc.
Kwoh Cheng Sun, Siren, to Wautoma 54982.
Thomas W. Weis, Waukesha, to 513-D Bellarmine Drive, West, Joliet, Ill. 60436.
Bernard J. Werra, 725 American Avenue, Waukesha 53186.

REMOVED FROM MEMBERSHIP

Eleanor C. Struck, Washington County, resigned.
John T. Murphy, Door-Kewaunee County, removed per county secretary.
Robert I. Hiller, Milwaukee County.
Donald Arthur Crippen, Eau Claire-Dunn-Pepin County, transferred to Georgia.
Rudolph P. Froeschle, Dane County, transferred to New York.
William G. Healy, Dane County, transferred to Iowa.
George S. Metcalf, Rock County, removed per county secretary.
John G. Noble, Green County, removed per county secretary.
L. G. Duluc, Green County, removed per county secretary.
Dayton Burkholder, Eau Claire-Dunn-Pepin County, removed per county secretary.
W. W. Fieber, Fond du Lac County, transferred to Nebraska.

DEATHS

Gilbert F. Fitzgerald, Milwaukee County, February 15, 1965.
Nordahl O. Gunderson, non-member, February 21, 1965.
Josef Seilin, Langlade County, February 22, 1965.
William C. Liefert, Milwaukee County, March 4, 1965.
Delos F. Doyle, La Crosse County, March 7, 1965.
William A. Joseph, Milwaukee County, March 19, 1965.
Homer D. Ludden, Iowa County, March 19, 1965.

OBITUARIES *continued from page 42*

American College of Radiology, member of the American Roentgen Ray Society, American Radium Society, Radiological Society of North America, American Association for the Advancement of Science, Dane County Medical Society, State Medical Society of Wisconsin, and the American Medical Association, and he was also a past president of the Wisconsin Radiological Society. He served for nine years as a commander in the U.S. Navy Reserve, with two years of active duty.

Surviving are his widow and two daughters, Mrs. Charles L. Pember, Columbus, and Mrs. Donald V. Hooper, Milwaukee.

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Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

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Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Hanson, R. J., *et al.*: J. Urol. *79*:1016 (July) 1958. 2. Middletown, J. E.: Brit. M. J. *ii*:497 (Aug. 31) 1957. 3. Today's Drugs, Brit. M. J. *i*:1475 (May 26) 1962. 4. Brumfitt, W., *et al.*: Lancet *i*:130 (Jan. 20) 1962. 5. Anderson, K. N., *et al.*: J.A.M.A. *187*:87 (Feb. 22) 1964.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

REVIEW OF PHYSIOLOGICAL CHEMISTRY
By Harold A. Harper, Ph.D., Professor of Biochemistry, University of California School of Medicine, San Francisco, Biochemist Consultant to the Clinical Investigation Center, U.S. Naval Hospital, Oakland, and Biochemist Consultant to St. Mary's Hospital, San Francisco. 9th edition. Lange Medical Publications, Los Altos, Calif. 1963. 437 pages. Price: $6.00.

MEDICAL PHARMACOLOGY
By Andres Goth, M.D., Professor of Pharmacology and Chairman of the Department, The University of Texas Southwestern Medical School, Dallas, Texas. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 585 pages. Price: $11.75.

REVIEW OF MEDICAL PHYSIOLOGY
By William F. Ganong, M.D., Associate Professor of Physiology, University of California School of Medicine, San Francisco, and Consulting Physiologist, Kaiser Foundation Hospital, San Francisco. Lange Medical Publications, Los Altos, Calif. 1963. 577 pages. Price: $6.50.

SURGICAL PATHOLOGY
By Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Mo., Surgical Pathologist, The Medical Center, St. Louis, Mo., Consultant to the Armed Forces Institute of Pathology, in collaboration with Harvey R. Butcher, Jr., M.D., Associate Professor of Surgery, Washington University School of Medicine, St. Louis, Mo. 3rd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 1244 pages. Price: $18.75.

ELECTROCARDIOGRAPHIC NOTEBOOK
By Irené Ferrer, M.D., Associate Professor of Clinical Medicine, Department of Medicine, Columbia University College of Physicians and Surgeons; Visiting Physician, The First Medical (Columbia University) Division, Bellevue Hospital; Director, Electrocardiographic Laboratory, Columbia Presbyterian Medical Center, New York. 2nd edition. Hoeber Medical Division, Harper and Row, Publishers, New York 16, N. Y. 1964. 112 pages. Price: $2.75.

THE PATHOGENESIS OF LEPROSY
Ciba Foundation Study Group No. 15; edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. Little, Brown and Co., Boston, 1963. 101 pages. Price: $2.95.

THE IMMUNOLOGICALLY COMPETENT CELL: ITS NATURE AND ORIGIN
Ciba Foundation Study Group No. 16; edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Julie Knight, B.A. Little, Brown and Co., Boston. 1963. 110 pages. Price: $2.95.

ALCOHOL AND CIVILIZATION
Edited by Salvatore Pablo Lucia, M.D., Sc.D., Professor of Medicine and Preventive Medicine; Chairman of the Department of Preventive Medicine; Lecturer in Medical History and Bibliography; Consulting Physician in Oncology; University of California School of Medicine, San Francisco, Calif. McGraw-Hill Book Co., Inc., New York, San Francisco, Toronto, London. 1963. 416 pages.

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY
Volume 2. Edited and assembled by John Adriani, M.D., Professor of Surgery, Tulane University School of Medicine, Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, Director, Department of Anesthesiology, Charity Hospital of Louisiana, New Orleans, La. C. V. Mosby Co., St. Louis, Mo. 1964. 478 pages. Price: $10.75.

THE CARE OF THE GERIATRIC PATIENT
Edited by E. V. Cowdry, Ph.D., Sc.D. (Hon.), F.R.M.S. (Hon.), Professor Emeritus of Anatomy, Washington University, Director of Research, Scientific Associates, Inc., St. Louis, Mo. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1963. 566 pages. Price: $11.85.

SQUIBB PRODUCT REFERENCE FOR THE MEDICAL PROFESSION
Published by E. R. Squibb and Sons, New York. January, 1964. 324 pages.

DISORDERS OF LANGUAGE
Ciba Foundation Symposium. Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1964. 356 pages. Price: $11.00.

THE PROSPECT OF IMMORTALITY
By Robert C. W. Ettinger. Doubleday and Company, Inc., Garden City, N. Y. 1964. 190 pages. Price: $3.95.

ENDOTRACHEAL ANESTHESIA
By Noel A. Gillespie, M.D. Revised and edited by Betty J. Bamforth, M.D., and Karl L. Siebecker, M.D. The University of Wisconsin Press, Madison. 1963. 235 pages. Price: $5.50.

SMOKING AND HEALTH
Report of the Advisory Committee to the Surgeon General of the Public Health Service. U.S. Department of Health, Education, and Welfare Public Health Service Publication No. 1103. U.S. Government Printing Office, Washington, D. C. 20402. 1964. 387 pages. Price: $1.25.

LYSOSOMES
Ciba Foundation Symposium. Edited by A.V.S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. Little, Brown and Co., Boston. 1963. 446 pages. Price: $11.50.

GUIDES TO PSYCHIATRIC REHABILITATION
A Cooperative Program with a State Mental Hospital, Bertram J. Black, Editor. Cooperating Agencies: Altro Health and Rehabilitation Services, Inc.; New York State Division of Vocational Rehabilitation; Rockland State Hospital; New York State Department of Mental Hygiene. National Institute of Mental Health, Project No. OM-50. Published by Altro Health and Rehabilitation Services, Inc., New York, N. Y. 10016. 1963. 81 pages. Price: $2.50.

BOOKSHELF *continued*

BETWEEN US WOMEN
A Woman Doctor's Handbook on Pregnancy and Birth, by Dr. Laura E. Weber. Doubleday and Company, Inc., Garden City, N. Y. 1962. 153 pages. Price: $1.95.

THE DIAGNOSIS OF GENITO-URINARY NEOPLASMS
By Victor F. Marshall, M.D., Clinical Professor of Surgery (Urology), Cornell University Medical College, Attending-in-charge, Urology, James Buchanan Brady Foundation, The New York Hospital, Associate Attending, Urological Service, The Memorial Hospital, New York, N. Y. American Cancer Society, Inc. 1963. 61 pages.

CLINICAL INVESTIGATION IN MEDICINE: LEGAL, ETHICAL, AND MORAL ASPECTS
An Anthology and Bibliography edited by Irving Ladimer, S.J.D., and Roger W. Newman, LL.B. Boston University Law–Medicine Research Institute. 1963. 517 pages.

FITNESS FOR THE WHOLE FAMILY
Edited by Paul Dudley White, M.D., and Curtis Mitchell. Doubleday and Company, Inc., Garden City, N. Y. 1964. 302 pages. Price: $4.95.

CONSULTATIONS IN MEDICINE: COMMON COMPLAINTS
A Collection of Medical Articles from CONSULTANT Magazine. Smith, Kline and French Laboratories, Philadelphia, Pa. 1964. 206 pages. Price: $3.00.

MARRIAGE COUNSELING IN MEDICAL PRACTICE
A Symposium edited by Ethel M. Nash, M.A., Lucie Jessner, M.D., and D. Wilfred Abse, M.D. The University of North Carolina Press, Chapel Hill. 1964. 368 pages.

STOCHASTIC MODELS IN MEDICINE AND BIOLOGY
Edited by John Gurland. The University of Wisconsin Press, Madison. 1964. 393 pages. Price: $6.00.

PROCEEDINGS—CONFERENCE OF PROFESSIONAL AND SCIENTIFIC SOCIETIES
Sponsored by Commission on Drug Safety, Chicago 1, Ill. 1963. 179 pages.

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION
By John J. Hanlon, M.S., M.D., M.P.H., Director of Community Health Services, City of Philadelphia; Professor and Chairman, Department of Preventive Medicine and Public Health, Temple University School of Medicine, Philadelphia, Pa. 4th edition. C. V. Mosby Co., St. Louis, Mo. 1964. 719 pages. Price: $11.50.

ATLAS AND MANUAL OF DERMATOLOGY AND VENEREOLOGY
By Prof. Dr. W. Burckhardt, Director of the Municipal Policlinic for Skin and Venereal Diseases, Zürich, Switzerland. Translated and edited by Stephan Epstein, M.D., Marshfield Clinic, Marshfield, and Clinical Associate Professor of Dermatology, University of Minnesota School of Medicine, Minneapolis. 2nd American edition. Wilkins and Wilkins Co., Baltimore 2, Md. 1963. 290 pages. Price: $16.50.

OCULAR AND ADNEXAL TUMORS: NEW AND CONTROVERSIAL ASPECTS
Symposium sponsored by Department of Ophthalmology, Baylor University College of Medicine. Editor, Milton Boniuk, M.D., Assistant Professor of Ophthalmology and Chief, Sections of Ophthalmic Pathology and Ocular Oncology, Baylor University College of Medicine, Houston, Texas. C. V.

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Mosby Co., St. Louis, Mo. 1964. 511 pages. Price: $25.00.

INFECTIOUS DISEASES OF CHILDREN

By Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine; Director of Pediatrics, Bellevue Hospital Center; Director of Pediatrics, University Hospital, New York, N. Y., and Robert Ward, M.D., Professor and Chairman, Department of Pediatrics, University of Southern California School of Medicine; and Physician-in-Chief, Children's Hospital, Los Angeles, Calif. 3rd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 423 pages. Price: $15.75.

LIFE INSURANCE MEDICAL RESEARCH FUND

Nineteenth Annual Report, 1963–1964. Boyertown Publishing Co., Boyertown, Pa. 1964. 82 pages.

1963–64 ANNUAL REPORT OF THE JOHN AND MARY R. MARKLE FOUNDATION

522 Fifth Avenue, New York 10036. 1964. 92 pages.

SMOKING AND YOUR LIFE

By Alton Ochsner, M.D. Julian Messner, Inc., New York 18, N. Y. 1964. 144 pages. Price: $3.00.

CASE STUDIES IN OBSTETRICS AND GYNECOLOGY

By F. Jackson Stoddard, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee, Wis. W. B. Saunders Co., Philadelphia and London. 1964. 312 pages.

MODERN TREATMENT

Volume 1, No. 5. Treatment of Epilepsy, by Guest Editor, Russell N. DeJong, M.D., and Treatment of Arithritis, by Guest Editor, Carl M. Pearson, M.D. Hoeber Medical Division, Harper and Row, Publishers. Published bimonthly at 49 East 33rd Street, New York, N. Y. 10016. Subscription: $16.00 per year.

REPORT OF THE COMMISSION ON DRUG SAFETY

Foreword by Lowell T. Coggeshall, M.D. 1964. 228 pages.

THE VISUAL FIELDS: A TEXTBOOK AND ATLAS OF CLINICAL PERIMETRY

By David O. Harrington, A.B., M.D., F.A.C.S., Clinical Professor of Ophthalmology, University of California School of Medicine, San Francisco, Calif.; Consultant in Ophthalmology, Veterans Administration Hospital, Fort Miley, San Francisco, Calif. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 386 pages. Price: $16.00.

PEDIATRIC NEUROLOGY

Edited by Thomas W. Farmer, M.D., Professor of Neurology, University of North Carolina School of Medicine, Chapel Hill, N. C. Hoeber Medical Division, Harper and Row, Publishers, New York, N. Y. 10016. 1964. 690 pages. Price: $18.50.

NEWCASTLE DISEASE VIRUS: AN EVOLVING PATHOGEN

Proceedings of an International Symposium held July 15–17, 1963, at the University of Wisconsin. Edited by Robert Paul Hanson. University of Wisconsin Press, Madison and Milwaukee, Wis. 1964. 352 pages. Price: $7.50.

BLOOD PROGRAM IN WORLD WAR II

Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C., U. S. A.; Associate Editor, Elizabeth M. McFetridge, M.A. Office of the Surgeon General, Department of the Army, Washington, D. C. 1964. 922 pages.

SURGERY OF THE BREAST

By Louis H. Jorstad, M.D., F.A.C.S., F.I.C.S., Consulting Surgeon, St. Luke's Hospital, Missouri Baptist Hospital and Frisco Employees' Hospital Association, St. Louis, Mo.; Consulting Surgeon, Ellis Fischel State Cancer Hospital, Columbia, Mo., with the collaboration of Meredith Jorstad Payne, M.D., F.A.C.S., Assistant, Department of Surgery, Washington University School of Medicine, St. Louis, Mo.; Associate Surgeon, St. Luke's Hospital, St. Louis, Mo.; Consulting Surgeon, Homer G. Phillips Hospital, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo. 1964. 220 pages. Price: $15.00.

STEREOSCOPIC MANUAL OF THE OCULAR FUNDUS IN LOCAL AND SYSTEMIC DISEASE

By Frederick C. Blodi, M.D., Associate Professor of Ophthalmology, State University of Iowa College of Medicine, Iowa City, Ia., and Lee Allen, Associate in Ophthalmology, State University of Iowa College of Medicine, Iowa City, Ia. C. V. Mosby Co., St. Louis, Mo. 1964. 132 pages. Price: $32.50.

MODERN TREATMENT

Volume 1, No. 6: Treatment of Headache, guest editor, Arnold P. Friedman, M.D. Treatment of Acid Peptic Disease, guest editor, Howard M. Spiro, M.D. Published bimonthly by Hoeber Medical Division, Harper & Row, Publishers, New York, N. Y. 10016. November 1964. 1500 pages per year. Price: $16.00 per year.

THE FADING FAMILY PHYSICIAN

One Man's Experiences. By Judge M. Lyle, M.D. Henry L. Geddie Co., Fort Worth, Tex. 76102. 1965. 95 pages. Price: $3.00 postpaid.

THE MASK OF SANITY

By Hervey Cleckley, M.D., Clinical Professor of Psychiatry, Medical College of Georgia, Augusta, Ga. 4th edition. C. V. Mosby Co., St. Louis, Mo. 1964. 510 pages. Price: $9.75.

OPPORTUNITIES IN A PSYCHIATRY CAREER

By Henry A. Davidson, M.D. Vocational Guidance Manuals, Universal Publishing and Distributing Corp., New York 17, N. Y. 1964. 144 pages. Price: $1.45 paperback, $2.65 cloth.

HEART ATTACK: NEW HOPE, NEW KNOWLEDGE, NEW LIFE

By Myron Prinzmetal, M.D., in collaboration with William Winter, patient. Preface by Walter C. Alvarez, M.D. Simon and Schuster, Inc., New York 20, N. Y. 1965. 232 pages. $1.75 paperback, $4.50 cloth.

THE HISTORY OF SURGICAL ANESTHESIA

By Thomas E. Keys, A.B., M.A., librarian of the Mayo Clinic, Rochester, Minn., Associate Profes-

Age 12-13—not too soon to pay attention to her acne

At the first sign of acne...the first comedone or seborrhea... "this is the time to institute preventive measures—the time to try to prevent progression to pustulation and scarring."[1] Regular, frequent washing with pHisoHex, antibacterial detergent, can enhance any acne management program, help to clear acne skin faster and better.

pHisoHex is more than a superior cleanser. It contains 3 per cent hexachlorophene, an optimal amount. This powerful antibacterial agent is deposited on the skin where, as an invisible, tenacious film, it degerms between washings. Among 67 acne patients who used pHisoHex, "...results were eminently satisfactory."[2] When pHisoHex was used as the wash in another series of 42 acne patients, "no patient failed to improve."[3]

Why not recommend three or four pHisoHex washings daily and exclusively to all your acne patients? pHisoHex provides superior cleansing action and is nonalkaline, hypoallergenic and "kind" to skin. And for "...a very effective topical treatment for acne vulgaris"[4] prescribe keratolytic pHisoAc® Cream along with pHisoHex. pHisoAc Cream contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent. It dries, peels and masks lesions. Of 100 patients treated with pHisoHex and pHisoAc (and a low-fat diet), 79 showed good-to-excellent improvement.[4]

pHisoHex is available in unbreakable plastic squeeze bottles of 5 oz. and 1 pint, in plastic bottles of 1 gallon. pHisoAc is supplied in tubes of 1½ oz. For complete acne therapy, prescribe or recommend the special *Combination Package* containing both pHisoHex and pHisoAc Cream.

References: 1. Handelman, Cathryn C.: Early management of acne, *Pediat. Clin. North America* 8:265, Feb., 1961. **2.** McLean, I. E. D.; Graham, K. T., and East, M. O.: The treatment of acne; a trial of "pHisoHex," *Practitioner* 189: 82, July, 1962. **3.** Hodges, F. T.: Therapeutic applications of an antiseptic detergent, *GP* 14:86, Nov., 1956. **4.** Wexler, Louis: Treatment of acne vulgaris, *Clin. Med.* 70:404, Feb., 1963.

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sor, History of Medicine, Mayo Foundation, Graduate School, University of Minnesota. Introductory Essay by Chauncey D. Leake; concluding chapter, "The Future of Anaesthesia," by Noel A. Gillespie; appendix by John F. Fulton. Dover Publications, Inc. New York 14, N. Y. 1963. 193 pages. Price: $2.00 paperback.

CONTROL OF GLYCOGEN METABOLISM

Ciba Foundation Symposium. Consulting Editor, W. J. Whelan, Ph.D., D.Sc., F.R.I.C., and Editor for The Ciba Foundation, Margaret P. Cameron, M.A. Little, Brown and Co., Boston. 1964. 434 pages. Price: $12.50.

THE RETINAL VESSELS

Comparative Ophthalmoscopic and Histologic Studies on Healthy and Diseased Eyes. By R. Seitz, M.D., First Assistant, University Eye Clinic, Tuebingen, Germany. Translated by Frederick C. Blodi, M.D. Associate Professor of Ophthalmology, State University of Iowa College of Medicine, Iowa City, Ia. C. V. Mosby Co., St. Louis, Mo. 1964. 186 pages. Price: $14.50.

REHABILITATION MEDICINE

A Textbook on Physical Medicine and Rehabilitation. 2nd edition. By Howard A. Rusk, M.D., Professor and Chairman, Department of Physical Medicine and Rehabilitation, New York University Medical Center, New York, N. Y., with the editorial assistance of Eugene J. Taylor, A.M. C. V. Mosby Co., St. Louis, Mo. 1964. 668 pages. Price: $15.50.

INDUSTRIAL AND TRAUMATIC OPHTHALMOLOGY

Symposium of New Orleans Academy of Ophthalmology. By Arthur H. Keeney, M.D., Hedwig S. Kuhn, M.D., Roderick MacDonald, Jr., M.D., Frank W. Newell, M.D., Joseph F. Novak, M.D., Ralph W. Ryan, M.D., and Lorenz E. Zimmerman, M.D. C. V. Mosby Co., St. Louis, Mo. 1964. 321 pages. Price: $14.50.

CURRENT PRACTICE IN ORTHOPAEDIC SURGERY

Volume 2. John P. Adams, B.S., M.D., F.A.C.S., Editor, Professor of Orthopedic Surgery and Chairman of Orthopedic Section, George Washington University School of Medicine and Hospital, Washington, D. C. C. V. Mosby Co., St. Louis, Mo. 1964. 231 pages. Price: $13.50.

DISTILLED WISDOM

Compiled and edited by Alfred Armand Montapert. Prentice-Hall, Inc., Englewood Cliffs, N. J. 1964. 355 pages. Price: $5.95.

FAMILY MEDICAL GUIDE

Edited by Donald G. Cooley. Art direction by Paul Zuckerman. Meredith Press, New York-Des Moines. 1964. 816 pages.

THE SMALL INTESTINE—ITS FUNCTION AND DISEASES

By Thomas W. Sheehy, M.D., F.A.C.P., Assistant Chief, Department of Gastroenterology, Walter Reed Army Institute of Research, Washington, D. C.; Associate Professor, Department of Medicine, University of Puerto Rico School of Medicine, and Martin H. Floch, M.S., M.D., Assistant Attending Physician, Montefiore Hospital, The

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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arteriolly. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

BOOKSHELF *continued*

Bronx, New York. Hoeber Medical Division, Harper and Row, Publishers, New York 16, N. Y. 1964. 479 pages. Price: $20.00.

ATLAS OF GENERAL SURGERY
By Joseph R. Wilder, M.D., F.A.C.S., Director of Surgery, Hospital for Joint Diseases, New York, N. Y. Illustrated by Shirley Baty. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 325 pages. Price: $23.50.

PROCEEDINGS OF WORLD FORUM ON SYPHILIS AND OTHER TREPONEMATOSES
Sponsored by American Social Health Association, American Venereal Disease Association, U.S. Department of Health, Education, and Welfare, and Public Health Service; Participating Agencies: World Health Organization and International Union Against the Venereal Diseases and the Treponematoses. Public Health Service Publication No. 997. U.S. Government Printing Office, Washington, D. C. 20402. 1964. 521 pages. Price: $4.00.

THE PSYCHEDELIC EXPERIENCE: A MANUAL BASED ON THE TIBETAN BOOK OF THE DEAD
By Timothy Leary, Ph.D., Ralph Metzner, Ph.D., and Richard Alpert, Ph.D. Psychedelic Monograph I. University Books, New Hyde Park, N. Y. 1964. 159 pages.

CARDIAC ARREST AND RESUSCITATION
By Hugh Stephenson, Jr., B.S., M.D., F.A.C.S., Professor of Surgery, University of Missouri School of Medicine, Columbia, Mo. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 501 pages. Price: $15.00.

X-RAY TECHNOLOGY
By Charles A. Jacobi, B.Sc., R.T. (A.R.R.T.), Assistant Professor, Medical X-Ray Technology, and Radiation Health and Safety Officer, Radioactive Byproduct Installations, Oregon Technical Institute, Klamath Falls, Ore., and Don Q Paris, R.T. (A.R.R.T.), Chairman, Medical X-Ray Technology, Oregon Technical Institute, Klamath Falls, Ore. 3rd edition. C. V. Mosby Co., St. Louis, Mo. 1964. 452 pages. Price: $11.50.

CORNEAL CONTACT LENSES
By Members of the Contact Lens Section, Department of Ophthalmology, Baylor University College of Medicine, Houston, Texas. Editor, Louis J. Girard, M.D., F.A.C.S.; Associate Editors, Joseph W. Soper and Whitney G. Sampson, M.D. C. V. Mosby Co., St. Louis, Mo. 1964. 329 pages. Price: $19.75.

DYNAMIC PATHOLOGY: STRUCTURAL AND FUNCTIONAL MECHANISMS OF DISEASE
By Maurice M. Black, M.D., Professor of Experimental Pathology, New York Medical College; Attending Pathologist, Flower and Fifth Avenue Hospitals, New York, N. Y., and Bernard M. Wagner, M.D., Professor and Chairman, Department of Pathology, New York Medical College; Pathologist, Flower and Fifth Avenue Hospitals, New York, N. Y. C. V. Mosby Co., St. Louis, Mo. 1964. 296 pages. Price: $8.00.

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See JAMA May 10 for complete scientific program—forms for advance registration and hotel accommodations.

1965 **Wisconsin**

May 20: Postgraduate Program, Jackson Clinic, Madison.

June 4–6: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

June 7: Wisconsin State Medical Golf Association, annual spring golf tournament, Tuckaway Country Club, Milwaukee.

June 11: Wisconsin Academy of General Practice, conference on "The Infant Who Fails to Survive," Uphoff's Motel, Wisconsin Dells.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Sept. 13: Wisconsin State Medical Golf Association, annual fall tournament, Janesville Country Club.

Sept. 23: 11th Annual Fall Cancer Conference, University of Wisconsin Medical Center, Madison.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

May 21–23: Tri-State meeting of Illinois, Iowa, and Wisconsin Associations of Blood Banks, Davenport, Ia.

May 24–26: ACP Course No. 15, Royal Victoria Hospital on campus of McGill University, Montreal, Que., Can.

May 25: 5th International Thyroid Conference, Rome, Italy.

May 30–June 3: Medical Library Association Annual Meeting, Philadelphia, Pa.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 7–11: ACP Course No. 16, University of Iowa, Iowa City.

June 8–11: Catholic Hospital Association of United States and Canada, golden jubilee convention, Kiel Auditorium, St. Louis, Mo.

June 9–11: American College of Physicians Postgraduate Course No. 17, New York University Medical Center, New York, N. Y.

June 14–16: University of Colorado School of Medicine, religion and medicine conference, Estes Park, Colo.

June 14–17: American Proctologic Society, 64th annual meeting, Minneapolis, Minn.

June 16: Scientific Session of American Cancer Society, Philadelphia, Pa.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20: AMA-ASHA, seventh annual preconvention session on school health, New York City.

June 20–24: Woman's Auxiliary to American Medical Association, 42nd annual convention, Americana Hotel, New York City.

June 20–24: American Medical Association, Section on Radiology, New York City.

June 20–24: American Medical Association, 114th annual convention, New York Coliseum, New York.

June 21: American Medical Association and American College of Chest Physicians, combined meeting, Barbizon–Plaza Hotel, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

July 16–17: 19th annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

July 26–30: Continuation course on cardiac arrhythmias, Hahnemann Medical College and Hospital, Philadelphia.

July 29: 2nd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology, Vienna, Austria.

Aug. 2–6: Department of Pediatrics and Office of Postgraduate Medical Education of University of Colorado School of Medicine, 8th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 8: 8th International Anatomical Congress, Wiesbaden, Germany.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30–Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15, 1965–June 15, 1966: Tutorial program in cardiology offered by Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16: Seventh International Congress of General Practice, Salzburg, Austria.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 13–14: American Heart Association Council on Arteriosclerosis, annual meeting, Hotel Deauville, Bal Harbour, Fla.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Oct. 28–30: American College of Gastroenterology, annual course in postgraduate gastroenterology, Americana Hotel, Bal Harbour, Fla.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30–Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–4: Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI meeting, Pick–Congress Hotel, Chicago, Ill.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Chest Physicians Annual Meeting

The American College of Chest Physicians will hold its 31st annual meeting June 17–21 at the Waldorf–Astoria Hotel, New York City.

Scientific sessions will cover thromboembolic disease, pulmonary hypertension, transplantation, hyperbaric oxygen therapy, mycobacterial disease, cardiac perplexities, infiltrative lung disease, coronary artery disease, hypertension, emphysema, acute respiratory failure, cardiovascular emergencies, and congenital heart disease.

Monday, June 21, the American Medical Association and the American College of Chest Physicians will hold a combined meeting at the Barbizon–Plaza Hotel.

For additional information, write: American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

AMA–ASHA Session on School Health

The seventh annual AMA–ASHA preconvention session on school health will be held the evening of June 20 in conjunction with the AMA annual convention in New York City. All physicians interested in school health programs are invited to attend. Educators, nurses, dentists, and other related professionals are also being invited.

For additional information, write: Department of Community Health and Health Education, AMERICAN MEDICAL ASSOCIATION, 535 North Dearborn St., Chicago, Ill. 60610.

Wisconsin Chapter, American Academy of Pediatrics

ONE DAY CONFERENCE

Symposium on

THE CHILD WHO FAILS TO THRIVE

Uphoff's Motel, Wisconsin Dells,

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Open to all M.D.s without registration fee. . . All A.A.G.P Members Who Attend Entitled to 5 Hours of Educational Credit

Speakers:

The Subtly Starving Child

JAMES G. HUGHES, M.D.: Memphis, Tennessee
Professor of Pediatrics, University of Tennessee College of Medicine

A Practical Investigation of Inborn Errors of Metabolism

VINCENT C. KELLEY, M.D.: Seattle, Washington
Professor of Pediatrics, University of Washington School of Medicine

The Congenital Defects

RALPH V. PLATOU, M.D.: New Orleans, Louisiana
Professor and Head of the Department of Pediatrics
Tulane University School of Medicine

Pitfalls of Drug Administration in Children

HARRY C. SHIRKEY, M.D.. Birmingham, Alabama
Assistant Professor of Pediatrics
Medical College of Alabama

No registration fee or advance registration is required. Those wishing housing are urged to make reservations direct, by writing UPHOFF's MOTEL, Wisconsin Dells. *Specify you are attending this conference.*

Ob–Gyn Board Examination

The next scheduled Part I (written) examination will be held at various examining centers in the United States, Canada, and military bases outside the continental United States July 2 at 10 a.m.

Applications received for the next Part II examination to be given in Chicago, Ill., in April 1966 will be reviewed by the Credentials Committee in September and notifications will be mailed to candidates on or about October 1.

The 1965 Bulletin outlining current requirements should be available upon request about July 1. Application forms and bulletins may be obtained by writing: Clyde L. Randall, M.D., Secretary and Treasurer, American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, N. Y. 14216.

Applicants are urged to familiarize themselves with the current rules and regulations, particularly in view of the changes in application and examination schedules effective this year. Diplomates of this Board are requested to keep the office of the Secretary informed of their current address.

Rocky Mountain Cancer Conference

Denver will be the site of the 19th annual Rocky Mountain Cancer Conference July 16–17 at the Brown Palace Hotel. Some of the nation's distinguished speakers on the subject of cancer will be featured.

Dr. James Z. Appel, president-elect of the American Medical Association, and Dr. Murray M. Copeland, president of the American Cancer Society, will participate in the Conference which is held annually in Denver, and cosponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society.

Speakers on the scientific program include: Dr. Lauren V. Ackerman, professor of surgical pathology and pathology of the Washington University School of Medicine, St. Louis, Mo.; Dr. Joseph H. Burchenal, professor of medicine, Cornell University Medical College, and vice-president of Sloan–Kettering Institute, New York; Dr. Walter W. Carroll, Chicago surgeon, and Dr. Walter T. Murphey, chief, department of radiation therapy, Buffalo General Hospital, New York.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Ave., Denver, Colo. 80218.

Of 341 patients with confirmed OB-GYN infections... 320 or 93.8% were treated successfully with Signemycin®

Note:
In 50 cases of serious puerperal and postabortal infections treated with Signemycin, complete cure was observed in 49 patients.* Duration of therapy ranged from three to eight days. Appropriate surgical measures were applied as indicated.

*Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958.

Condition	No. of Patients	No. Responded to Signemycin
Abortion, infected	45	44
Adnexitis (parametritis)	66	61
Cervicitis	18	18
Endometritis	64	61
Mastitis and breast abscess	44	42
Puerperal sepsis	14	14
Salpingitis	39	34
Other ob-gyn infections	51	46
Totals	341	320 (93.8%)

consistently effective...often when others fail

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Brief Summary and Bibliography follow.

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Fall Cancer Conference

The 11th Annual Fall Cancer Conference (The Cancer Scrimmage) will be held Saturday, September 25, at the University of Wisconsin Medical Center, Madison.

The scientific program will run from 9 a.m. to 12:15 p.m., with papers on cancer projects and recent developments given by the staff of the Division of Clinical Oncology, Dr. A. R. Curreri, director. Conference cosponsor is the American Cancer Society, Wisconsin Division. A special guest speaker from out of state is planned. Luncheon and the Southern California-Wisconsin football game follow.

A cancer chemotherapy session for Wisconsin physicians will be given Friday, September 24, from 9:30 a.m. to 4:30 p.m. This is a combined basic course in drugs and their uses against cancer with case clinics and problem solving of advanced cancer cases. This clinical cancer chemotherapy session is designed to dovetail with the Saturday cancer conference to make the two-day session an "in depth" approach to current cancer therapy.

Dr. Robert J. Samp, Division of Clinical Oncology, is program chairman. Further announcements and registration material will go out in July.

UW Postgraduate Program

Five distinguished guest professors along with staff of the University of Wisconsin Medical Center will lead a postgraduate program in medical education to be held August 26–28 on the UW campus in Madison.

The three-day session, entitled "Current Concepts in Surgery," is directed to the surgically oriented physician in four lecture, symposia and demonstration sessions and three intervals for reflection, visiting, and discussion.

Visiting professors who will head the sessions include Dr. Frank Glenn, Louis V. Atterburgy Stimson professor of surgery at Cornell University Medical College and surgeon-in-chief at the New York Hospital; Dr. Harold Laufman, professor of surgery, Northwestern University Medical School and attending surgeon, Passavant Memorial Hospital and Veterans Administration Research Hospital, Chicago;

Dr. George T. Shires, professor of surgery and chairman, Department of Surgery, Univeristy of Texas Southwestern Medical School, and general surgeon, Parkland Hospital, Dallas, Texas; Dr. Johann L. Ehrenhaft, professor of surgery and chairman, Division of Cardiovascular and Thoracic Surgery, University of Iowa College of Medicine, Iowa City, Iowa, and Dr. Clifford D. Benson, clinical associate professor of surgery, Wayne State University Medical School, Detroit, and surgeon-in-chief, Children's Hospital of Michigan, and surgeon, Harper Hospital.

Dr. Robert C. Hickey, professor of surgery, UW Medical Center, is coordinator of the program. Complete information may be obtained by writing to University of Wisconsin Extension, Room 401, Extension Building, Madison, Wis. 53706.

Jackson Clinic Postgraduate Meeting

The Spring Postgraduate Meeting of the Jackson Clinic and Foundation will be held at the Jackson Clinic building, Madison, on Thursday, May 20.

POSTGRADUATE COURSES AT THE VIENNA ACADEMY OF MEDICINE

The American Medical Society of Vienna in connection with the Vienna Academy of Medicine has a long and outstanding history. It was founded in 1879 with the primary purpose to facilitate contact and arrange courses of visiting English speaking doctors with the clinics of the faculty and its institutes. In its first 50 years more than 20,000 English-speaking doctors have received help through this organization. After the war the American Medical Society of Vienna was reorganized in 1953 and since that time three thousand doctors and postgraduate students have taken advantage of its facilities. Today courses and seminars of the Society offer a unique possibility for practical medicine. No lecture courses as such are given, however, practical sessions and actual patient examination and treatment, surgical operations, round table discussions and grand rounds are part of these seminars.

The medical school of the University of Vienna has nominal control over 52 major hospitals in Vienna with approximately 40,000 beds. Over 400 full professors, associate professors and assistants are in direct charge of these beds and therefore offer a postgraduate student a coordinated clinical pool for medical training with an extensive variety. These seminars are arranged individually for any single visiting doctor or any group, for a few days or a month as requested. Upon completion a Seminar Congress letter is issued. Special certificates are issued for studies of 3 months duration. Extended courses of 10 months may be set up leading to a University diploma. All these contacts are with English-speaking members of the clinics. The cost of these courses range from $1.00 to $6.00 per hour for seminars, and up to $70.00 a month for courses to obtain the University diploma. Life membership in the Society is $30.00 and associate membership $10.00.

The club headquarters of the Society are situated in the University section of Vienna and in close proximity to the University Clinics. It offers every possible amenity to the visiting doctor. The club rooms and extensive library have become a study center for English speaking doctors in Europe. Further information may be obtained by writing to the Secretary of the American Medical Society of Vienna, Universitaetsstrasse 11, Vienna 1, Austria.

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Note:
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*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded to Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

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Brief Summary and Bibliography follow.

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1965 CONVENTION PROGRAM

Wisconsin State Medical Assistants Society

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JUNE 4–5–6

Theme: Passport to Progress

FRIDAY, JUNE 4

8:30 a.m.-9:00 p.m.: Registration

9:00 a.m.-11:30 a.m.: Pre-Convention Board Meeting

12:00 noon: Luncheon for Executive Board, Advisors, and Delegates
Courtesy: Wisconsin Physicians Service

1:30 p.m.-5:00 p.m.: House of Delegates Meeting
Presiding: *Aleen Piepenburg*, President, WSMAS

8:00 p.m.-10:00 p.m.: International Interlude (Welcoming Party)

SATURDAY, JUNE 5

8:00 a.m.-5:00 p.m.: Registration

9:00 a.m.-9:30 a.m.: General Session
Presiding: *Aleen Piepenburg*
INVOCATION: *Alice L. Roelse*, President-Elect, WSMAS
PLEDGE OF ALLEGIANCE
WELCOME: *Marvis Sitkoski*, President, Milwaukee County Medical Assistants Society
WELCOME: *Robert F. Purtell, M.D.*, President, The Medical Society of Milwaukee County

9:30 a.m.-10:15 a.m.: "The Role of the Museum in Medical Progress", by *Gordon L. Peckham*, Curator, Museum of Medical Progress and Stovall Hall of Health, Prairie du Chien

10:30 a.m.–11:15 a.m.: "Project Hope in Peru", by *William B. Gallagher, M.D.*, La Crosse

12:00 noon: President's Luncheon
Presiding: *Aleen Piepenburg*
INVOCATION: *Edith C. Murphy*
PRESENTATION OF CHARTERS
PRESENTATION OF MEMBERSHIP AWARD

2:00 p.m.-2:45 p.m.: "Training is Always", by *Daniel C. Braun, M.D.*, Assistant Medical Director, United States Steel Corporation

2:45 p.m.-3:30 p.m.: "Formula for a Successful Meeting", by *Professor Raymond H. Myers*, University of Wisconsin–Milwaukee Speech Department

continued next column

MEDICAL MEETINGS *continued*

Registration will be at 1 p.m. The scientific session will start at 2 p.m. with a welcome by Dr. L. E. Holmgren, chairman of the Clinic staff.

Chairman for the first part of the program will be Dr. J. H. Morledge. At 2:10 Dr. V. E. Demergian (Plastic & Reconstructive Surgery) will speak on "Recent Advances in Plastic Surgery;" at 2:30 Dr. Barbara Brew (Obstetrics & Gynecology), "Amenorrhea: Diagnosis and Management" (with patient presentations); "Cardioversion in the Management of Cardiac Arrhythmias" by Dr. D. W. Hurst (Internal Medicine), at 2:50; at 3:10 Dr. R. B. Ainslie and Dr. T. L. Hartridge (Otorhinolaryngology), "The Surgery of Hearing: Patient Selection and Techniques."

Following an intermission with refreshments and time for viewing of the technical exhibits, the second part will begin at 4 p.m. with Dr. D. William Hurst as chairman. Dr. W. J. McAweeney (Internal Medicine) will speak on "Acute Renal Failure: Recognition, Etiology, and Management," at 4:20 guest speaker, Dr. Laslo Kaveggia, "Chronic Urinary Tract Infections in Childhood." Doctor Kaveggia is with the Department of Urology, Children's Memorial Hospital and Northwestern University School of Medicine, Chicago. A panel discussion on "Duodenal Ulcer, Genetic and Psychosomatic Aspects, Medical and Surgical Management" will begin at 5:00 with Dr. W. B. Parsons, Jr. (Internal Medicine) as moderator. Panelists will be Drs. L. E. Holmgren (Surgery), H. C. Ashman (Internal Medicine), Margaret Prouty (Pediatrics), and W. L. Waskow (Radiology).

A social hour will begin at 5:30 at the Capital Room, Loraine Hotel, followed by dinner at 6:15. Prof. Lee Dreyfus, director of the University of Wisconsin Television Station WHA-TV, will address the group on the subject "My Shadow and Me."

MEDICAL ASSISTANTS *continued*

6:30 p.m.-7:15 p.m.: Social Hour

7:30 p.m.-10:00 p.m.: Banquet
Presiding: *Aleen Piepenburg*
GUEST SPEAKER: *Dr. Frank E. X. Dance.* "The Medical Assistant: Future and Fortune"
INSTALLATION OF OFFICERS
ACCEPTANCE SPEECH: *Alice L. Roelse*

10:00 p.m.-11:30 p.m.: President's Reception

SUNDAY, JUNE 6

10:00 a.m.: Brunch
Presiding: *Alice L. Roelse*, President
SUMMARY OF PROCEEDINGS OF HOUSE OF DELEGATES
ANNOUNCEMENT OF 1965–1966 STANDING AND SPECIAL COMMITTEES
ADJOURNMENT

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Severe Interventricular Septal Defect Complicated by Pregnancy

By HENRY E. DeGROOT, M.D. and JOSEPH C. FRALICH, M.D., Racine, Wisconsin

■ APPROXIMATELY 2 per cent of women going through pregnancies have associated heart disease. Of these, 95 per cent are rheumatic and 5 per cent congenital. The mortality rate associated with congenital heart disease is approximately 3 per cent, 25 per cent of the deaths occurring during pregnancy and 75 per cent in the puerperium.[1] Advice to a patient with congenital heart disease either to attempt pregnancy or to continue, once pregnant, must be based on these figures until more information becomes available. Therapeutic abortion after the first trimester carries an increased risk to the mother.

Contrary to earlier opinions, it is now generally stated that congenital heart disease accompanied by a high degree of cyanosis is not in itself a contraindication to pregnancy. Congenital defects which do or may produce shunting of blood from the right to the left ventricle such as interventricular septal defect, patent ductus, or Eisenmenger's complex, even though producing no previous disability whatsoever, may be associated with sudden unexpected alarming symptoms immediately following emptying of the uterus, and the patient may die. The alarming symptoms are not those of heart failure, but are rapid breathing and a rapid heart rate without venous congestion. Patients die slowly or rapidly of asphyxia and exhaustion. Symptoms are apparently due to the onset or aggravation of a right-to-left shunt of blood.[2]

Recently a patient with a soft left parasternal systolic murmur, cyanosis, clubbing, polycythemia, and a previous catheterization diagnosis of inoperable Eisenmenger's syndrome became pregnant in spite of advice to the contrary. Although she was physically active and well compensated prior to her pregnancy, the advisability of termination of pregnancy was considered. Only four cases of Eisenmenger's complex associated with pregnancy were found in the literature.[3] One case proved by autopsy died postpartum of cerebrovenous thrombosis; diagnosis was based on catheterization studies in two other cases; confirmatory data were lacking in the fourth. Polycythemia and clubbing were not noted in any of the four cases. Even if all were typical Eisenmenger's complex, the small number of cases precluded any conclusions. Therefore, in view of the reasonably low mortality rate associated with congenital heart disease in general, compared to the risk involved with interruption of pregnancy, the patient was advised to continue with the pregnancy.

Case Report. This 26-year-old white woman was first seen in 1960. Activity had been restricted during childhood because of a murmur discovered at age 6. At age 15 examination revealed a questionable apical systolic murmur but no clubbing or cyanosis. A blood count, electrocardiogram, and chest x-ray film were considered normal. Polycythemia was noted at age 18 by a routine

blood count. At that time she complained of slight fatigue and dyspnea on exertion. This did not prevent her from working eight hours a day as a secretary and from engaging in many additional social activities. At age 23 she began to notice blueness of her nails and lips when extremely tired and with exertion. She denied dyspnea or cough.

Physical examination revealed clubbing and cyanosis of the nails and cyanosis of the lips. Her blood pressure was 110/80 mm Hg; pulse was 64. Examination of the heart revealed no cardiomegaly. There was a grade 1, apical, left parasternal, systolic murmur heard in the fourth interspace. Pulmonic second sound was increased in intensity. Remainder of the physical examination was normal.

An electrocardiogram was reported as abnormal with evidence of right ventricular hypertrophy of the systolic overload pattern (Fig 1). Chest x-ray film showed slight prominence of the pulmonary conus with no cardiac enlargement. The hemoglobin was 17.1 gm/100 ml; hematocrit reading 58%; red blood cell count 6,700,000/cu mm; white blood cell count 14,650/cu mm, with a normal differential.

The patient was referred to the university hospital for cardiac catheterization in September 1960. This revealed arterial oxygen saturation of 81%. RV pressure was 100/–5 with an end diastolic of 15 mm Hg. PA pressure was 122/70, and the systemic pressure was 118/79. Dye dilution curves showed the presence of bidirectional shunt at the ventricular level. Cardiac output was 1.9 L/min/M^2 and pulmonary blood flow index 1.7 L/min/M^2. Left-to-right index 0.283 L/min and right-to-left index was 0.707 L/min. CONCLUSION: Evidence of bidirectional shunt at the ventricular level with severe hypertension. DIAGNOSIS: Eisenmenger's complex.

The patient, who had recently married, was advised against pregnancy. During the following two years, she did well. She did, however, have three episodes of painless hemoptysis persisting for a few days with x-ray evidence of pulmonary infiltration suggesting either pulmonary emboli or intrabronchial hemorrhage. Erythrocytosis became more pronounced during this time, the hemoglobin reaching levels of 19.0 gm/100 ml and the hematocrit reading 61%. She became pregnant in December 1962. She

Fig. 1—Electrocardiogram showing changes in QRS complexes of V leads compatible with right ventricular hypertrophy.

was seen at weekly intervals during the entire pregnancy and was not allowed to work after the third month. She was placed on a low-salt regimen at that time, and activity was moderately restricted during the remainder of her pregnancy.

A hemoglobin level of 16.5 in April dropped to 14.9 gm/100 ml during the second trimester. A pulse rate of 60 rose to 96 during the last trimester. Blood pressure remained stable at 110/70 until August when it rose to 140/100 mm Hg accompanied by ++ pitting edema and + albuminuria. At this time she was given a daily dosage of 50 mg hydrochlorothiazide (Hydro-Diuril). There was a total weight gain of only 8 lb. Venous pressure in the right antecubital vein was 110 in April, and 90 mm of water in May. The heart murmur was almost inaudible during the last six months of her pregnancy. There was no change in the chest x-ray films taken in April, May, and September. An electrocardiogram in June 1963 showed inversion of previously upright T-waves in V_1.

In August 1963, exactly one month prior to the expected date of confinement, the patient was admitted to the hospital in active labor, which had begun three hours earlier with spontaneous rupture of the membrances. Physical examination was unchanged. Therapy with 600,000 units of penicillin and 0.5 gm of streptomycin was initiated twice daily for the next five days. She received meperidine hydrochloride (Demerol) and promethazine (Phenergan) for analgesia and 1% lidocaine (Xylocaine) pudendal block for anesthesia. Three hours after admission an uneventful low-forceps delivery of a 4 lb 5½ oz normal male infant was accomplished. The third stage was uneventful and the midline episiotomy was repaired with the total blood loss estimated at 250 ml. Sand bags and a binder were applied to the abdomen immediately following delivery. The sand bags were removed 12 hours later and the binder 36 hours later. Elastic stockings were placed on the lower extremities and were removed three days later.

The immediate postpartum course was uneventful. Blood pressures of 144–168/94 during labor stabilized at 100–110/84–90 mm Hg. Pulse rate which had been 64–70 during labor rose to 90–100 following delivery. Except for the persistent cyanosis of the nail beds and mild dyspnea on exertion, the first two postpartum days were very encouraging. By the third day, the patient began to complain of some dyspnea when sitting up, and the pulse rate had risen to 112. Although the patient continued to feel well, there was a gradual but progressive rise in the pulse rate to a rate of 124 on the eighth postpartum day. She was digitalized with no improvement. Dyspnea and cyanosis became more pronounced and the patient was described as "being exhausted." She became extremely apprehensive to the point of panic on several occasions. She was given sedation with morphine and meprobamate. She fought off attempts to administer oxygen therapy but was placed in an oxygen tent without benefit. On the eleventh day the pulse rate was 136, and the hemoglobin level dropped from 15 on admission to 12.4 gm/100 ml. One unit of packed red blood cells was given slowly with no change. The following evening after an intensive supportive psychotherapy attempt, the patient showed marked improvement. By the following morning, the pulse had decreased to 84. She

Fig. 2—The heart viewed from the left ventricle. Arrow points to the interventricular septal defect.

was alert, rested, and feeling well out of the oxygen tent. The hemoglobin level had risen to 16.4 gm/100 ml. The respite was short-lived, and during the following two days she again became quite apprehensive, dyspneic, and lethargic; and she complained of some pain in the left subcostal area. On the seventeenth postpartum day she died quite suddenly and quietly.

She had been afebrile throughout the postpartum course. Blood pressure had remained quite stable. Blood chemistry studies, electrolytes, and two blood cultures were normal. Chest x-ray films and electrocardiograms did not change significantly throughout the hospitalization. Her hemoglobin level on the final day again dropped to 12.8 gm/100 ml with a hematocrit reading of 42%.

At autopsy the heart was dilated but firm, the right atrium and ventricle being particularly prominent. The great vessels at the base showed a normal relationship, but the pulmonary artery was larger than the aorta. The ductus arteriosus was 5 mm in diameter but was not patent. The heart measured 12 x 12 x 7 cm and weighed 360 gm. Internal examination revealed normal valves, the pulmonary valve being 8 cm, the aortic valve 6 cm, and the tricuspid and mitral valves 10 cm in circumference. There was a thrombus on the wall of the right ventricle, but no thrombi or emboli in the aorta or other major vessels. The pulmonary artery was speckled with yellow deposits extending into the small ramifications of the major branches. The upper portion of the interventricular septum possessed an ovoid defect measuring 2 cm in diameter rimmed with dense fibrous connective tissue free of vegetation (Figs 2 & 3). The endocardium of the right ventricle was mottled by gray-yellow streaks, most prominent in the lining of the pulmonary conus. Less definite but similar changes were present in the endocardium of the left ventricle. In the endocardium of the pulmonary conus, there was also a gray, white fibrous patch opposite the interventricular septal defect. The left ventricular wall was 18 mm thick and the right ventricular wall 13 mm thick at the pulmonary conus. The lungs contained slight atelectasis of the right lower lobe and a 4-cm hemorrhagic infarct in the left upper lobe. The lungs were not congested. The outstanding

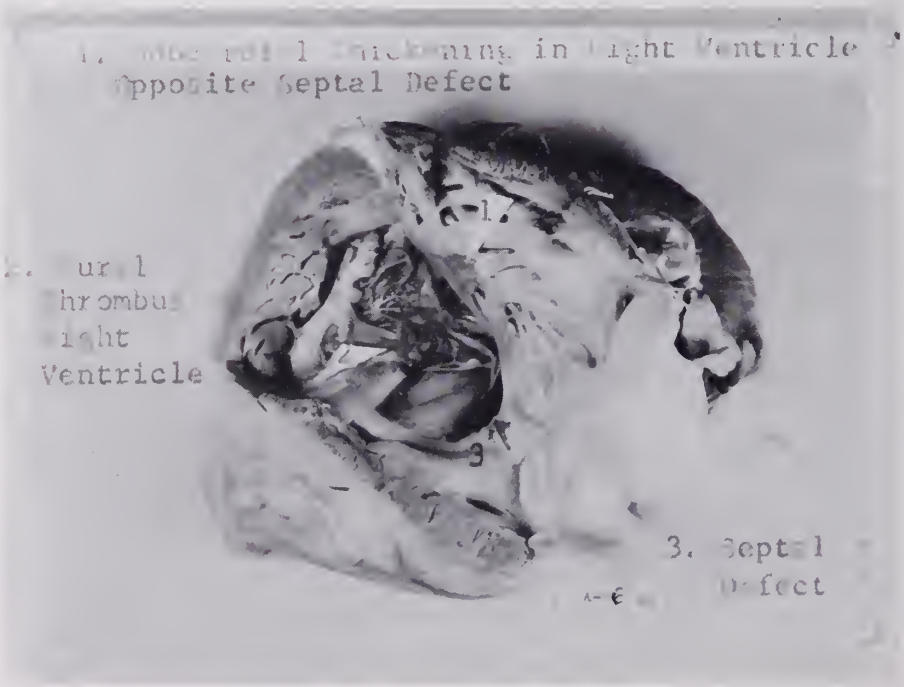

Fig. 3—View of the heart from the right side. Arrow points to the interventricular septal defect.

feature was the prominence and relative stiffness of the branches of the pulmonary artery, which were normal in thickness. There was an 8-cm infarct in the spleen. The brain was not examined. The rest of the tissues were unremarkable.

Microscopic examination revealed that in the right ventricle there were areas of edema between muscle fibers with considerable fatty degeneration of the fibers. The nuclei of the myocardial fibers were large, irregular, and hyperchromatic. Cholesterol deposits were present within the intima of the pulmonary artery. The wall itself contained numerous capillaries. There was moderate fibrosis about the muscle layer of the larger branches of the pulmonary artery. The aorta was normal. There was congestion of the pancreas, cortices of the kidneys, spleen, and submucosa of the intestine.

Pathological studies revealed a large interventricular septal defect, dilatation and arteriosclerosis of the pulmonary artery, hypertrophy of the right ventricle of the heart with fatty degeneration of the myocardium, focal endocardial fibrosis of the pulmonary conus, mural thrombus of the right ventricle, small infarct of the left lung, splenic infarct, early hypostatic pneumonia, and cloudy degeneration of the liver.

Comment. Although the absence of transposition of the great vessels made this not a typical Eisenmenger's complex, the size and position of the interventricular septal defect produced physiological effects and anatomic changes making it clinically indistinguishable. Since this is probably the most severe case of interventricular septal defect complicated by pregnancy to be studied, it seems worthy of record. The usual case of interventricular septal defects is not complicated by cyanosis, polycythemia, or clubbing. In severe cases, pulmonary hypertension ensues. Bidirectional or reduced blood flow occurs when the systemic pressure is exceeded. In pregnancy, a decrease in peripheral resistance may enhance this reversal.[4]

The most recent comprehensive list of reported interventricular septal defects with pregnancy is recorded by Mendelson.[3] Of 110 patients only 6 died. In addition to this, 6 other cases are recorded with 1 death.[5, 6] Of these cases only 10 developed heart failure during pregnancy. Of the deaths, 2 died of antepartum heart failure; 1 of paradoxical embolus; 3 of postpartum collapse, 2 following Cesarean section; 1 following podalic version; and 1 of postabortal endocarditis and heart failure. Although few of these cases are reported in detail, the implication is that nearly all were simple cases with no evidence of cyanosis, clubbing, or polycythemia. The 2 cases of Hamilton and the 1 case of Abbot which Hamilton describes all resemble our patient insofar as the mode of death.[7]

The overall mortality rate for patients with uncomplicated interventricular septal defects who become pregnant is low. With modern therapeutic advances the number of patients with severe defects who reach childbearing age is certain to increase. Accurately predicting the risk for the individual patient is hazardous because of the paucity of reported cases. The usual classification of heart disease by the American Heart Classification prior to and during pregnancy does not appear to be useful in predicting fatal cases. Cyanosis in itself has proved not to be a contraindication to pregnancy. However, cyanosis, polycythemia, and pulmonary hypertension of a degree sufficient to consider the heart lesion inoperable appear to be a combination of factors which make survival after pregnancy extremely unlikely. Since similar cases which may have had pregnancy interrupted are not reported in the literature, the only way in which further conclusions can be reached will be the recording of documented cases in the literature.

Summary. A case of a large high interventricular septal defect with right ventricular hypertrophy, pulmonary hypertension, cyanosis, and polycythemia, which was diagnosed as Eisenmenger's complex by cardiac catheterization prior to pregnancy is reported. The patient survived an uneventful pregnancy and delivery only to die in a state of exhaustion 17 days postpartum. All of the known precautions to prevent complications during gestation and in the postpartum period were taken. Autopsy revealed a normal relationship of the great vessels, a small splenic infarct, and a small pulmonary infarct. Death appeared to be due to myocardial failure and hypoxia.

Although the relative safety of heart disease in pregnancy is statistically established, unexpected deaths continue to occur postpartum. The potential of right-to-left shunt is especially likely to cause sudden alarming

symptoms immediately after delivery or in the postpartum period. Cases of interventricular septal defects reviewed in the literature confirm this fact. There is hope that further cases of severe interventricular septal defect similar to this one will be reported so that more reliable criteria for continuing or recommending interruption of pregnancy in such cases will be made available.

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HYPERMAGNESEMIA IN RENAL FAILURE: ETIOLOGY AND TOXIC MANIFESTATIONS

RANDALL, RUSSELL E., JR., COHEN, M. DAVID, SPRAY, CHARLES, C., JR., AND ROSSMEISL, ELSIE C.—*Annals of Internal Medicine*, 61:73 (July) 1964.

"Magnesium is the fourth most abundant cation in the body. In a 70 Kg man there are approximately 1,000 mEq of magnesium in bone, another 1,000 mEq within cells, and 20 mEq in plasma and interstitial fluid." If magnesium in the diet is curtailed, renal conservation occurs. In renal disease this ability may be impaired.

Data are presented from a study of 5 patients with severe renal failure who developed marked hypermagnesemia after the administration of magnesium. In 2, this was given parenterally to correct a presumed deficit; in the others, in the form of laxative or antacid medicines. The effects of hypermagnesemia were shown to be nausea, vomiting, malaise, hypotension, drowsiness, difficulty in voiding and defecating, dysarthria, ataxia of gait, decreased reflexes and respirations, coma, EKG changes, carotid sinus sensitivity, and cardiac arrest.

Severe renal disease limits the capacity to excrete magnesium which is roughly proportional to the impairment in glomerular filtration.

Magnesium contained in laxative and antacid medicines previously considered nonabsorbable may be absorbed to a significant degree. "Patients with severe renal failure, ingesting customary doses of standard preparations, may sustain significant elevations of the serum magnesium with manifestations of toxicity in as little as three days."—Reprinted from *International Medical Digest*, December 1964.

INTRODUCTION OF TRANQUILIZERS reversed the trend toward increasing population of mental hospitals: From the establishment of the first American public mental hospital in 1773 until 1956, there were always more patients in mental hospitals at the end of each year than there had been at the beginning of the year. But in 1956—the first year of widespread application of psychopharmaceuticals—the hospital population *decreased* by over 7,800. There are now 43,000 fewer patients in state and local mental hospitals than there were in 1955, the peak year.

76 Eyes Obtained during Year by Wisconsin Lions Eye Bank

At the annual meeting of the Wisconsin Lions Eye Bank, announcement was made that after a year's operation under sponsorship of the Lions Foundation of Wisconsin, 76 eyes were obtained from donors within Milwaukee County. Eyes were used for corneal transplant surgery in Milwaukee, Racine, and Madison; in Chicago, Ill., Memphis, Tenn., and Washington, D.C. Eyes not suitable for corneal surgery were used for pathological research and for preservation of the cornea and sclera.

The bank's executive board installed *Dr. Richard O. Schultz*, Milwaukee, chairman of the Department of Ophthalmology, Marquette University School of Medicine, as medical director, and *Dr. Erwin E. Grossmann*, also of Milwaukee, as associate director. In addition to these two, the medical executive board includes *Drs. John B. Hitz, A. C. Kissling, Jr.*, and *Thomas Sawyer*, Milwaukee, and Roger Lehman, Wood.

Waukesha Memorial Hospital and the Gundersen Clinic, La Crosse, were named affiliates of the Wisconsin Eye Bank. Affiliates are furnished with instructions and material to facilitate procurement and shipping of eyes to the bank and to surgeons throughout the states. Local Lions Clubs underwrite the costs and assist in the bank's function.

The Wisconsin Lions Eye Bank is located at 763 N. 18th St., Milwaukee, Wis. 53233.

Post Infarction Syndrome

Presentation of Two Cases

By GEORGE E. GUTMANN, M.D., Janesville, Wisconsin

■ IN THE PAST DECADE many reports have appeared in the literature describing the post infarction syndrome. Dressler originally drew attention to this condition in 1956.[1] The complications of myocardial infarction are numerous, such as post infarction embolization, pericarditis, aneurysmal formation of the myocardium, sudden death due to cardiac tamponade as a result of cardiac rupture, ventricular fibrillation, and congestive heart failure. Now the post infarction syndrome is added to the list of complications. Two cases will be presented.

Case 1.—A 40-year-old man was admitted to the hospital in February 1953 with the complaint of severe precordial chest pain radiating into the left shoulder. Electrocardiographic changes were limited to negative T waves in lead aVF and lead III and only very slightly negative in lead II. The erythrocyte sedimentation rate rose to 76 mm/hr in four days and the initial white blood cell count was 15,000/cu mm. He was febrile for seven days. Treatment consisted of bedrest and bishydroxycoumarin (Dicumarol) therapy. Recovery was uneventful and the patient returned to work after three months. The family history was noncontributory. There was a past history of rheumatic fever.

The second hospital admission occurred in November 1961. He was awakened by vise-like left shoulder pain, radiating into the front of the chest on the left. This was accompanied by profuse cold perspiration. The physical examination was not remarkable except for muffled heart tones. The lungs were clear, the abdomen was normal, the peripheral pulsations were intact. Electrocardiographic changes were characteristic of acute posterolateral wall infarction. The initial erythrocyte sedimentation rate was 7 mm/hr, white blood cell count 14,350/cu mm, and blood cholesterol 236 mg/100 ml. The initial serum glutamic oxalopyruvic transaminase (SGOT) was 194 units, rose to 410 units, and later dropped to 149 units. Two weeks later the erythrocyte sedimentation rate had risen to 101 mm/hr.

Treatment consisted of oxygen, rest, and analgesics. Warfarin was started immediately. The prothrombin time was maintained between 20 to 30 per cent of normal.

Two days after admission to the hospital a pericardial friction rub was detected and there were rales at the lung bases. Penicillin was administered because of coughing. The pericardial friction rub became pleuropericardial in type. It remained audible for the next 10 days. At that time warfarin and penicillin were discontinued and tetracycline was substituted. The fever was spike-like in character and did not resemble the usual febrile reaction of acute myocardial infarction. On the twentieth hospital day only a faint friction rub was heard, and three days later warfarin therapy was started again. The patient had left-sided chest pain the following day with the pain also radiating into the left shoulder. One month after admission the presence of post infarction syndrome was suspected. Warfarin was discontinued and prednisolone therapy was instituted. His temperature became normal and improvement was almost immediate. The erythrocyte sedimentation rate dropped rapidly. He was sent home with a regimen of one daily dose of 5 mg of prednisolone. Three days later he had a temperature of 103.5 F. and chest pain. The prednisolone dosage was increased and there was almost immediate drop in temperature. Gradually the prednisolone dosage was reduced and discontinued in February 1962. Since then he has been symptom-free and has returned to work.

Chest x-ray films showed cardiac enlargement and pneumonic infiltration in the left lower lung segments.

Presented at the Annual Meeting of the Wisconsin Society of Internal Medicine, Sept. 13, 1963, Sturgeon Bay, Wis.

Case 2.—A 58-year-old man was admitted to the hospital in May 1962 with a history of precordial pain of one weeks duration. It radiated into both arms and into the neck. It was precipitated by slight exertion, associated with dyspnea, and relieved by rest.

The family history was significant in that his mother, father, two brothers, and one sister died of heart attacks. The past history was not contributory.

Physical examination revealed him to be heavy-set and apprehensive. Blood pressure was 150 systolic and 100 diastolic. Heart tones were of poor quality. A friction rub was not heard. There were basilar rales. The electrocardiogram was consistent with acute anterior wall infarction. The SGOT values rose from 50 units to 239 units and then dropped to 146 and eventually to 66 units. The erythrocyte sedimentation rate rose from 21 mm to 82 mm/hr. One month later it had dropped to 31 mm/hr at the time of discharge. The blood cholesterol was 181 mg/100 ml. The patient was started on warfarin therapy. He was digitalized. On the second hospital day a loud pericardial friction rub was heard and two days later a pleuropericardial rub. Both disappeared five days later. The fever lasted seven days and reached a high of 102.6 F. He was discharged a month after admission. It was considered necessary to continue anticoagulant therapy at home.

The second admission took place 25 days later. Three days before admission he had pain in the left supraclavicular region which was aggravated by deep inspiration. There was evidence of pleural effusion on physical examination but the Homan's sign was negative in both legs. Neck veins were flat. He was febrile. The erythrocyte sedimentation rate was elevated to 76 mm/hr. 1150 ml of straw-colored fluid was removed from the left pleural cavity. The fluid contained 5.3 gm/100 ml of protein. The LDH was 215 units. The culture did not show any bacterial growth and there were no tumor cells. The histoplasmin and tuberculin skin tests were negative. Post infarction syndrome was suspected, warfarin therapy was discontinued, and prednisolone was administered for five days. There was a prompt subsidence of the fever and the patient was discharged on digitalis and chlorothiazide (Diuril). Antibiotics were not administered.

In November 1962 he was readmitted to the hospital. The night before he had vague pain in the left shoulder and sharp pains in the left fifth intercostal space. A friction rub was heard over the left anterior chest wall. Breath sounds were diminished and there were moist rales. His temperature rose to 100 F. The pain did not resemble angina. Blood pressure was 118 systolic and 80 diastolic. The heart was enlarged to the left but murmurs could not be heard. Homan's sign in both legs was negative. The erythrocyte sedimentation rate was 73 mm/hr and the white blood cell count was 12,300/cu mm. There were nonhemolytic streptococci in the sputum. The chest x-ray film showed evidence of infiltration and fluid. Treatment consisted of tetracycline and prednisolone. He was continued on 10 mg of prednisolone per day at home.

Since November 1962 this patient has been on continuous prednisolone therapy. Several attempts were made to discontinue this medication but it always had to be given again, at first in larger and then gradually decreasing dosages. He now takes approximately 5 mg of prednisolone three times weekly. He feels well and there is no evidence of heart failure at present. He continues his work as a salesman.

Discussion. The two cases described fulfill the criteria for the post infarction syndrome established by Dressler in 1959,[2] as well as in his original article in the J.A.M.A. in 1956.[1] Dressler evaluated 10 patients who were seen up to June 1955. They all had myocardial infarctions. Later they developed a combination of complications consisting of pericarditis, pleurisy, and pneumonitis. They had prolonged and recurrent fever and precordial pain. The pericardial rub would usually be of long duration. There was leukocytosis and the erythrocyte sedimentation rate was elevated in most instances. Chest pain was usually severe. Relapses of both pericarditis and pleuropericarditis or merely pleurisy were common. Dressler treated his patients with cortisone.

The following are Dressler's diagnostic criteria for the post infarction syndrome. Whereas the pericardial friction rub is usually found between the second and fourth days of illness in the pericarditis due to myocardial infarction, the rub of the post infarction syndrome is heard between the second and eleventh days of illness. The pericardial friction rub in myocardial infarction

is evanescent while it lasts from three days to three weeks in the post infarction syndrome. Pericardial effusion is extremely rare in myocardial infarction but common in the post infarction syndrome. The pericarditis in myocardial infarction is not associated with pleurisy or pneumonitis while it is often accompanied by pleurisy and pneumonitis in the post infarction syndrome. Our two patients exemplify the latter situation. Both of them had pericardial friction rubs as a result of the myocardial infarctions. In the first patient the pericardial and pleuropericardial rub lasted almost a month. Evidence of pulmonary involvement was noted on physical and x-ray examinations. With steroid therapy the signs of pleuropericarditis disappeared and the temperature fell to normal levels. It is too early to say whether the post infarction syndrome might not recur in the first patient. In the second patient there was apparent good recovery with continuous anticoagulant therapy and then the manifestations of the post infarction syndrome were those of pneumonitis and pleural effusion. The pleural effusion was noninflammatory in type. Prompt response to cortisone therapy was very characteristic and this is emphasized by Dressler and other writers. The patient still requires small doses of prednisolone.

Dressler[2] states that adrenal steroids are specific in that they promptly abolish fever and pain. He is also of the opinion that the anticoagulants in some obscure manner precipitate the post infarction syndrome. In this regard, it is interesting that one of the 10 patients of Cohen et al[3] was treated with both prednisolone and anticoagulants without apparent ill effect. It is worth noting that our first patient received bishydroxycoumarin during his first attack of myocardial infarction whereas the post infarction syndrome only took place when warfarin was given.

The incidence of post infarction syndrome, according to Dressler[2] is 3 to 4 per cent in recent myocardial infarctions. Dressler and Levitt[4] describe eight relapses of pericarditis over a period of 28 months in a 44-year-old man who was treated with cortisone. Carlen[5] reports two patients with recurrent post infarction syndrome in spite of bishydroxycoumarin withdrawal. Our second patient had several recurrences, consisting of pleural effusion and fever. Cohen et al[3] also

TABLE 1—*Pericarditis*

As Sign of Recent Myocardial Infarction	As Major Complication of Myocardial Infarction
Pericardial friction rub is usually heard between the second and fourth days of illness.	Pericardial friction rub is heard between the second and eleventh weeks of illness.
Pericardial friction rub is evanescent.	Pericardial friction rub lasts from three days to three weeks.
Pericardial effusion is extremely rare.	Pericardial effusion is common.
Pericarditis is not associated with pleurisy and pneumonia.	Pericarditis is often accompanied by pleurisy and pneumonitis.
Pericarditis does not recur.	Recurrences are a significant feature.

(From the A. M. A. Archives of Internal Medicine, Vol. 103, January 1959, Number 1.)

stress the recurrent pleuritic and pneumonic involvement, and state that antibiotics are of no avail. No organisms could be cultured from the pleural fluid from our second patient. The pneumonitis can be hemorrhagic in the post infarction syndrome. Only a few autopsy studies are available.

Weiser et al[6] report that pathological examinations merely revealed hemorrhagic types of pneumonia and no pulmonary emboli. The post infarction syndrome is generally a benign clinical situation although it might prove fatal if the pericardial effusion becomes severe enough to produce cardiac tamponade. Case 4 in Dressler's series died of cardiac tamponade.[2] At post mortem the lungs showed no signs of infarction and all the pulmonary artery branches were open. There was an extensive healing myocardial infarction, diffuse organizing pericarditis, interstitial pneumonitis and pleuritis, hemopericardium, bilateral hemothorax, and hemoperitoneum. Clinically then, if a patient has continued pericarditis, pneumonitis or pleural effusion without a positive Homan's sign, elevated temperature and atypical chest pain, the possibility of the post infarction syndrome must be considered. There might also be some clues with regard to the laboratory examination in the diagnosis of the post infarction syndrome. Samaras et al[7] state that fever, pleuropericardial pain and a high erythrocyte sedimentation rate were the three most constant findings in patients with post infarction syndrome. Davidson et al[8] make a similar statement in their discussion of the post infarction syndrome. They found 5 patients with this syndrome out of 500 patients with myocardial infarction, an incidence of less than one per cent. Our two cases had a high erythrocyte sedimentation rate until the post infarction syndrome was

apparently abolished with prednisolone. There are a few negative laboratory findings which would exclude recurrence of myocardial infarction. In the first place there are no characteristic electrocardiographic changes. The SGOT values are normal and bacteriological examinations are negative.

The etiology of the post infarction syndrome is unknown. There is a vague resemblance between the post commissurotomy syndrome and the post infarction syndrome. Auto-antigens and auto-antibodies have been demonstrated in myocardial infarction with or without the post infarction syndrome. Wolff and Grunfeld[9] feel that the mere presence of circulating auto-antibodies does not necessarily prove the post infarction syndrome to be due to auto-immune disease. The mechanism by which anticoagulant therapy produces the syndrome remains obscure. Wolff and Grunfeld state that "proof of the existence of the post infarction syndrome is difficult to establish and is just as difficult to deny its existence. This is particularly true since the diagnosis of myocardial infarction is sometimes made on sparse evidence particularly when made in retrospect or when a diagnosis of a silent coronary occlusion is made. It is worth noting that the post infarction syndrome and the anticoagulant era appeared simultaneously at a time when the diagnosis of acute idiopathic pericarditis was on the increase."[9]

Summary. Two cases of post infarction syndrome are presented. Their main clinical features were those of pericarditis, pleuropericarditis, recurrent fever, and pleural effusion. Treatment consisted of withdrawal of anticoagulants and the use of prednisolone. The differential diagnostic features of the post infarction syndrome, its clinical recognition, and its etiology are discussed.

The Pember–Nuzum Clinic.

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DRUGS ABOARD THE SPACECRAFT—GEMINI

America's first manned two-man spacecraft was equipped with drugs which could be used in flight or after landing, according to the Pharmaceutical Manufacturers Association.

Medical experts at National Aeronautics and Space Administration chose the drugs after testing to make sure they would withstand space flight and be effective and safe for use by astronauts.

Six types of drugs were aboard the Gemini—an anodyne and an analgesic (pain relievers); an antiemetic (to relieve or prevent nausea); an analeptic (to restore consciousness in coma or fainting); an antibiotic and an antimalarial. Drugs would be administered in flight only on orders of a ground-based flight surgeon.

Injectable drugs which will be available to the astronauts are Tigan brand of trimethobenzamide HCl, for nausea or vomiting due to motion sickness, reported to have a minimal sedation effect; and Demerol brand of meperidine HCl, to relieve pain.

Drugs for oral use will include Tigan in capsule form; Dexedrine brand of dextro-amphetamine sulfate for use against chronic fatigue, depression, or as an appetite depressant; Demerol in tablet form; an aspirin-phenacetin-caffeine pain reliever product; Achromycin, a tetracycline antibiotic; and Aralen, a chloroquine phosphate antimalarial preparation.

The spacecraft also carried water purification tablets.

A drug was used once previously by an American in space, when Astronaut Gordon Cooper administered a stimulant to himself 78 minutes before his relatively difficult manual re-entry into the atmosphere.

All of the drugs have undergone severe physical environmental tests by NASA to assay their ability to withstand temperature, pressure, vibration and other factors. Manufacturers, in preparing the drugs, have conducted rigid tests for quality control, safety and effectiveness.

Hypoglycemia with Neoplasia (Doege-Potter Syndrome)

By ROBERT S. BALDWIN, M.D., Marshfield, Wisconsin

■ "GREAT PROGRESS in chest surgery cannot be obtained until thoracotomy has become a safe procedure and until diagnostic thoracotomy has left us in no doubt." Karl W. Doege[1] wrote this in 1930 in his introduction to the article in which he described the first case reported in the literature of hypoglycemia associated with fibrosarcoma of the thoracic cavity. Roy P. Potter also reported this case in 1930[2] (Figs 1 & 2).

The tumor was removed in 1927, and the hypoglycemic manifestations disappeared. For six and one half years the patient was well; then the tumor returned along with the hypoglycemia. Details of the patient's subsequent course were reported by Baldwin.[3] The patient ultimately died in November 1934 of intestinal obstruction from incarcerated bilateral inguinal hernias.

This case, which has acquired historic significance, is important also because of its clinical features. Historically, the interest centers around two points: (1) The tumor was the largest removed from the chest under local anesthesia up to that time. This was made possible by the skill and courage of the surgeon, and by the anatomic situation. The tumor was attached by a pedicle and could be freed without damaging adjacent structures. Even so, two stages were

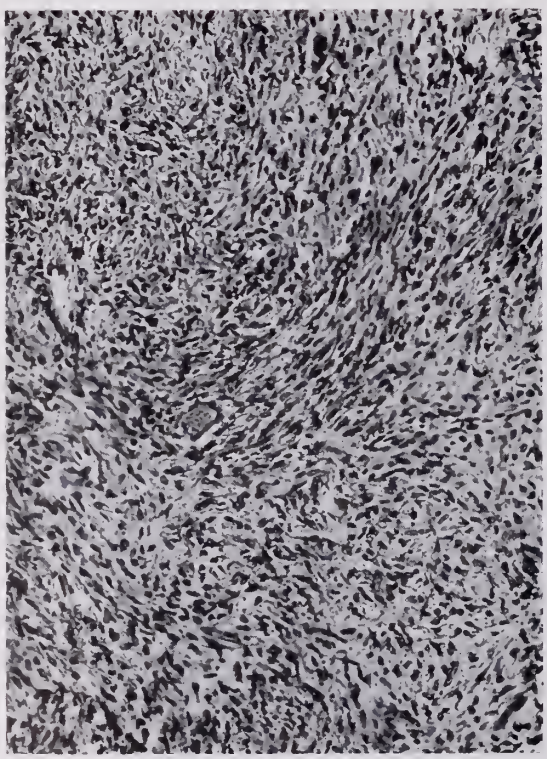
Fig. 1—Gross appearance of tumor removed in November 1927.

required to accomplish its removal. (2) This is the first reported case of hypoglycemia associated with a thoracic mesothelioma.

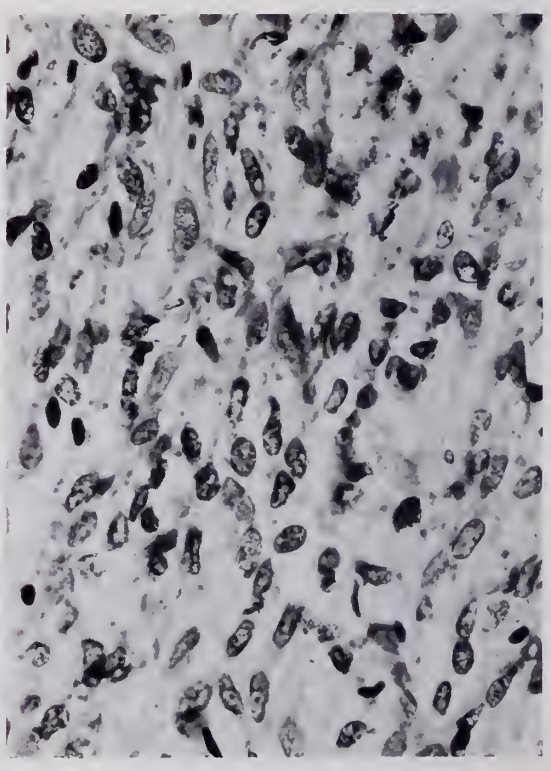
The clinical features were dramatized by the difficulty the clinicians had in recognizing that the symptoms were due to the hypoglycemia and that the hypoglycemia was caused by the tumor. The first difficulty arose because blood samples did not happen to be drawn at a time when the blood glucose was low. The second can be ascribed to the fact that no similar case had been reported. The observers had no precedent to suggest the idea that the relationship between the tumor and the hypoglycemia was causal and not purely fortuitous.

In 1927 when the tumor was removed, the records list only one blood glucose test. On October 24 it was 77 mg/100 ml. Blood was taken in the morning before breakfast.

Doege[1] explained the cerebral symptoms on a circulatory basis: anoxia (or "toxemia" as he called it) from interference with venous return from the head. He wrote, "But how to explain the maniacal seizures during the last two weeks? In the absence of kidney complications, a toxemia from that source can be excluded. It is more likely that the extreme displacement of the heart with the torsion and displacement of the large arteries and veins resulted in serious interference with the cerebral circulation, in the form of venous cerebral congestion, which caused insufficient oxygenation of the brain cells and consequent mental unbalance. Lack of nourishment to the brain and accumulation of toxemia in the brain could induce mental disturbance in the case under consideration just as readily as these disturbances are frequently noticed in cases of prolonged cardiac failure. In the absence of fainting spells and facial pallor or signs of anemia of the brain it could not have been the arterial blood supply that failed, and it is more likely that the venous return was responsible for the occasional cerebral disorders, as the patient's face appeared rather flushed.



(a)



(b)

Fig. 2—Microscopic appearance of tumor: (a) low-power, (b) high-power. (Photographs were made by Photographic Department of the Mayo Clinic through courtesy of Dr. Donald A. Scholz.)

"Insufficient respiratory exchange, of course, could also have resulted in toxicity of the blood and mental incoherence. However, such toxicity would most likely have led to coma rather than to violent maniacal seizures."

Even though the symptoms were relieved by the administration of glucose, apparently hypoglycemia was not given consideration as a cause.

In March 1934 when the cerebral symptoms returned, attention was directed principally to the central nervous system, and the explanation for them was sought there. A diagnosis of brain tumor was made. Also considered then and later were uremia, abscess on the left side of the chest wall, pancreatic adenoma, and abnormal liver function.

Also in March 1934, a neurologist consultant wrote as follows: "I would like to put the whole neurological picture on a toxic basis, with cerebral edema of a more or less diffuse nature giving transient neurological signs: low-grade papilledema, greater on the right, pupillary changes, left VIIth and right XIIth, and a right Babinski suggesting localization perhaps, but with delirium giving the impression of a diffuse process. This was then followed by prompt recovery and the fading out of the neurologic signs."

During March and April 1934, the patient was treated on several occasions at his local hospital. On April 7 he was transferred to a hospital in Michigan where he remained for one month. History at the Michigan hospital read in part as follows:

"The patient was perfectly well and active in his business until March 1, 1934, when on two or three consecutive mornings he was quite confused and had difficulty with his breakfast. Very promptly after breakfast the confusion would disappear. He would go to his office and feel perfectly well during the remainder of the day.

"On March 6, he went to the St. Joseph's Hospital where he remained until March 21. He had urinary difficulty at this time with retention.

"On March 22 at home he again was confused. This recurred on March 23. He was provided with an indwelling catheter which the patient himself removed on March 25.

"On the 28th and 29th of March, 1934, he appeared normal. On the 30th and 31st he was tired and confused and on April 2 was brought back to the hospital because he was confused and delirious.

"On April 3 he had another attack of delirium. At 11:00 A.M. 5% glucose was given intravenously. He reacted promptly and remained clear. His blood sugar on this day was 80. At 11:00 P.M. on the 3rd, he was again confused.

"On April 4 his blood sugar was reported as 80. He was very delirious and again reacted promptly to intravenous glucose and remained well the remainder of the day.

"On the 5th of April he went into delirium during the night and could not be aroused all morning. At about 1:00 P.M. he went into a deep coma, his eyes were glassy and fixed, his breathing labored, pulse 128, respirations 38. He could not be aroused even with painful stimulus. The chest was full of coarse rales and the family was called in and told he was dying. However, glucose was given at about 3:00 P.M. intravenously and he reacted very promptly.

"April 6, 1934, he had intravenous glucose and was well all day. He was transferred to St. Joseph's Mercy Hospital in Ann Arbor by train and during the ride he was given orange juice and sugar at frequent intervals by mouth.

"The diagnosis at the Marshfield Hospital was brain tumor.

"On the morning of the 7th he had an attack of delirium and was given 40 cc. of 30% glucose and he reacted promptly before the full amount was given. His blood sugar at this time was 40 mgs.%."

On Apr. 12, 1934, the Michigan physician wrote about the fasting blood sugar in the hypoglycemic level and stated: "This case is similar to one reported by Seale Harris in March of 1934, Annals of Internal Medicine."

Finally someone drew blood after an overnight fast at a time when the patient was having the disturbed cerebral function; and with help from the medical literature, hypoglycemia was at last established as the cause of his symptoms.

After the diagnosis of hypoglycemia was made, the means of controlling the patient's delirium, coma, and confusion was found. Then the cause for the hypoglycemia was searched for, but was not found.

The record stated: "It seems quite impossible at this time to state definitely just what is the etiologic factor producing the hypoglycemia."

In June 1934, the following notation was made on his chart at the Michigan hospital where he had again been admitted: "There is a history of similar attacks 7 years ago at which time he had surgical removal of a fibrosarcoma from the left chest. Following removal of the tumor the patient experienced symptoms such as he had on his present admission. Within a comparatively short period, however, the symptoms disappeared. He remained well for 7 years. X-ray examination suggests the possibility of return of the growth."

Although the relationship between the presence of the tumor and the hypoglycemic episodes is here indicated in words that speak the diagnosis to anyone with ears to hear, the following statement appeared in a letter dated July 30, 1934: "We have considered all the possible etiologic factors and have gotten no where. We also considered the possibility of a pancreatic adenoma, but have not recommended an exploratory laparotomy because he was a poor risk."

It was not until September 1934, that the clinicians came to the realization that extrapancreatic tumors could cause hypoglycemia. One wrote in a letter as follows: "The last set of x-ray films of Mr. K. were convincing enough to me that the most probable cause of his present condition is the recurrence of the tumor growth. This is the easiest to believe, and I am now all the more convinced after hearing a paper given by Dr. Wammock of Philadelphia at a meeting of the American Association for the Study of Neoplastic Diseases at Washington, D. C. He gave a report on the case of a tumor of the adrenal gland with hypoglycemia. I discussed the case personally with him and it seems very probable that Mr. K. could have a tumor involving the medullary portion of the adrenal which has the ability of depleting liver cells of sugar."

This is the first explicit statement I was able to find anywhere to indicate that the relationship between hypoglycemia and mesothelioma had been grasped. This new concept was given further consideration by Potter[4] and by Barrow[5] in the course of their correspondence late in 1934.

Barrow of Shreveport, La., was to give a paper on the x-ray treatment of hyperinsulinism at the Dec. 5, 1934, meeting of the Radiological Society of North America at Memphis, Tenn. He asked Potter to discuss his paper. In their correspondence in preparation for the presentation, both men advanced the idea that large tumors could cause hypoglycemia by producing an insulinoid substance. Quotations from their letters are as follows:

On Nov. 23, 1934, Potter wrote to Barrow: "We might easily conclude that if pressure from the large tumor he had in 1927 caused hypoglycemia, the presence of a new growth outside the pancreas again causing pressure might also cause the hypoglycemia now."

On Nov. 25, 1934, Barrow wrote to Potter: "I am just wondering in the history of your case, which showed a fibrosarcoma of the chest, if there was not a sufficient amount of insulinoid substance produced in this tumor to bring about hypoglycemia in 1927, and again if there might not be a metastases to the pancreas producing hypoglycemia now. Of course this is theoretical reasoning, but we know in many tumors there is produced an insulin type of secretion which frequently unbalances the sugar level."

In his discussion at the meeting Potter said: "We cannot conclude that this man had a tumor of the pancreas 7 years ago causing hypoglycemia at that time because he remained well for 6½ years following removal of the thoracic tumor and there was no treatment of the pancreas at that time.

"We might suspect that he now has a metastasis to the pancreas, knowing that the original tumor that was removed was malignant; however, this man has previously recovered from a similar attack following the removal of a thoracic tumor.

"I believe that we are justified in assuming that the hypoglycemia in 1927 was due to the presence of the thoracic tumor and that the hypoglycemia is again due to the presence of the large new growth which he now has.

"It is said that bronchogenic tumors may produce an insulinoid substance and it would appear that such is the case here, and that we are dealing with a case of hyperinsulinism of that type.

"Since no lesion of these organs was found, we must conclude that this was a case of hyperinsulinism due to secretion of insulinoid substance in a mediastinal tumor. The hyperinsulinism was relieved on removal of the tumor 7 years ago and reap-

pearing again on recurrence of the tumor 6½ years later."

Unfortunately, when Barrow's paper was published, Potter's discussion was not included. The material was obtained from a copy of Potter's original manuscript found in the patient's record.

Many investigators have been intrigued by this strange association of large tumors and hypoglycemia. They believe that in the mystery of this relationship lies the answer to some of the unknown factors in carbohydrate metabolism. As a clinical problem it has engaged the attention of surgeons and internists.[6] Pathologists[7] and biochemists[8] have devoted attention to it. The literature is fairly abundant; over 100 cases have been reported. Because Doege and Potter's case was the first, and because their articles did not give the subsequent course of the patient, and because of numerous requests for information about it, we have presented the follow-up data in detail. This case is of more than usual interest to the medical profession of Wisconsin since two of its early medical leaders, K. W. Doege and R. P. Potter, made the original reports. There is valid justification for calling it the Doege–Potter syndrome.

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RENAL ARTERY STENOSIS

Holley, Keith E., Hunt, James C., Brown, Arnold L., Jr., Kincaid, Owings W. and Sheps, Sheldon G. —*American Journal of Medicine*, 37:14 (July) 1964.

Advances in vascular surgery that permit reestablishment of flow distal to stenotic lesions of the renal arteries with apparent permanent relief of hypertension have reawakened interest in the more accurate determination of the presence of renal artery stenosis in hypertensive patients. Many methods have been used, and although, for instance, arteriography permits excellent visualization of the renal vascular anatomy, the functional significance of the findings is more difficult to determine. When relatively recent onset of hypertension is associated with unilateral stenosis and evidence of ipsilaterally diminished function, amelioration or complete relief may be expected from surgery. The prognosis with bilateral lesions is less well established.

Necropsy studies were made on 295 subjects of whom 256 were considered normotensive. Moderate or severe renal artery stenosis was found in 53 per cent of the 295 patients (49 per cent of the normotensive and 77 per cent of the hypertensive). Severe stenosis was uncommon in normotensives under 50 years of age; thereafter, it increased in frequency with age. Afferent arteriolar sclerosis of a moderate or severe degree was uncommon in normotensives under 60 years of age.

The authors conclude that, although on the basis of this small series it would seem that the etiologic significance of renal artery stenosis is greater in hypertensives under 50 years of age, the mere presence of atheromatous narrowing of the main renal arteries does not necessarily indicate a cause of, or relationship to, the presence of systemic hypertension.—Reprinted from *International Medical Digest*, December 1964.

ORAL CYTOLOGY COMMITTEE ORGANIZED

Earlier diagnosis of oral cancer is the aim of the Oral Cytology committee which was organized early in March, the State Board of Health reported.

David A. Barrett, D.D.S., was chosen chairman and Michael Arra, D.D.S., is the secretary. Doctor Barrett, South Milwaukee, represents the Wisconsin State Dental Society and Doctor Arra is director of the Division of Dental Health, State Board of Health, Madison.

The committee plans to enlist the aid of every dentist in the state in using the oral cytology smear technic when they examine patients.

Members of the Oral Cytology committee represent the Wisconsin State Board of Health, the Wisconsin State Dental Society, the American Cancer Society, Wisconsin Division, and the State Laboratory of Hygiene. They include, in addition to Doctor Barrett and Doctor Arra: J. S. Frey, D.D.S., Beloit; E. J. Surwillo, D.D.S., Milwaukee; Arthur Van Duser, M.D., Madison; A. S. Evans, M.D., Madison; G. I. Uhrich, M.D., La Crosse; Francis F. Schweinler, Madison; Stanley L. Inhorn, M.D., Madison; Weston C. Tormey, D.D.S., Madison.

Chemotherapy in Women with Trophoblastic Disease:

Choriocarcinoma, Chorioadenoma Destruens, and Complicated Hydatidiform Mole

By ROY HERTZ, M.D., GRIFF T. ROSS, M.D., and MORTIMER B. LIPSETT, M.D., Bethesda, Maryland

■ THE INITIAL REPORT of Li, Hertz and Spencer[1] outlined the rationale for and indicated the effectiveness of intensive intermittent therapy with folic acid antagonist, methotrexate, in women with metastatic trophoblastic disease.

The term "trophoblastic disease" is used to designate that spectrum of abnormalities of the chorion which includes hydatidiform mole, chorioadenoma destruens (or invasive mole), and choriocarcinoma. The term "metastatic trophoblastic disease" is applied when there is clinical, radiological, or hormonal evidence of disease outside the uterus.

All of these lesions arise initially from an abnormal villus. They may therefore be considered to have a common pathogenetic pathway. In fact, nearly half of the cases of choriocarcinoma are preceded by a hydatidiform mole. The vagaries of histological diagnosis in this group of tumors[2] are well known. Although the histological findings provide a general statistical basis for anticipating the clinical outcome in a large series of cases, the ultimate clinical course in any individual case is not predictable. Moreover, these tumors manifest an inherent variability in biological behavior which may be determined by the graftlike quality of the fetal tumor tissue as it resides in the maternal host.

Accordingly, our observations have led us to regard the clinical course of any patient with trophoblastic disease as the result of a precarious balance between factors of host resistance and tumor progression. At any point during this progress the host may rid herself of tumor or the tumor may extend in such a way as to lead to the patient's death. That we are dealing with a continuous process is clearly evident from those instances in which the entire gamut of histological diagnoses from hydatid mole to metastatic choriocarcinoma may be seen in a single individual. Thus, of 8 patients whose diagnosis during life was either hydatid mole or chorioadenoma destruens, 7 were found to have extensive choriocarcinoma at autopsy. We therefore consider that we are dealing with a dynamic process, termed trophoblastic disease, rather than with a series of distinctly separable clinical entities.

Nevertheless, we have systematically applied the criteria of Novak and Seah[3] in determining the histological classification of each case of trophoblastic disease. Accordingly, our therapeutic results are presented in relationship to the histopathological findings in each case on the basis of examination of all tissues available to us at the time of the patient's admission.

The data in the literature concerning the survivorship of patients with various forms of trophoblastic disease treated by classical surgical procedures are varied. This applies not only to the presumably less malignant forms of trophoblastic disease but even to metastatic choriocarcinoma. Thus Hreschchyshyn[4] describes a mortality of 95 per cent, or 40 of 42 cases with metastatic choriocarcinoma collected from the literature. Brewer et al[5] cite the five-year survival of 10 of 52 such cases, or a mortality of 81 per cent; and Manahan has reported a mortality of 89 per cent for similar cases of metastatic choriocarcinoma.[6] The variability in these findings results not only from the vagaries of

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From the Endocrinology Branch, National Cancer Institute. Doctor Hertz, a 1939 graduate of the University of Wisconsin Medical School, is now Chief of the Branch.

Adapted from an address delivered by Doctor Hertz on acceptance of the Medical Alumni Citation at the Wisconsin Medical Alumni Day, May 22, 1964, Madison.

TABLE 1—*Result of Chemotherapy in 111 Patients With Metastatic Trophoblastic Disease, Oct. 1, 1963*

Treatment	Choriocarcinoma		Mole, destruens and others		Total		
	Cases	Remissions	Cases	Remissions	Cases	Remissions	Per cent
MTX initially	58	29	29	16	87	45	51
Actino after MTX	17	10	6	2	23	12	52
Actino initially	7	3	6	4	13	7	54
MTX after Actino	5	2	2	2	7	4	57
Other*					35	4	9
				Total	111	72	64

*Vincaleukohlastine; combination therapy; 6-Mercaptopurine; Cytoxan; HN_2; DON.

TABLE 2—*Complete Remission Following Chemotherapy in 111 Cases With Metastases*

Histology	Cases	Remissions	Per cent remissions
Choriocarcinoma	75	45	60
Mole, destruens and other	36	27	75
Total	111	72	64

TABLE 3—*Duration of 72 Complete Remissions, Oct. 1, 1963*

Years	Number
<1	9
1	12
2	19
3	11
4	15
5	3
6	1
7	2

histological diagnosis but also from the relative availability of such ancillary therapeutic factors as transfusions, antibiotics, radiotherapy, and other modalities of medical and surgical management. Varying accuracy and duration of follow-up are also substantial factors in mortality data. Hence we lack a truly precise base-line for appraisal of the effectiveness of any newly introduced form of therapy.

In the past seven years we have treated 111 women with "metastatic trophoblastic disease" (Tables 1 and 2). At the initiation of therapy 75 of these patients had a histological diagnosis of choriocarcinoma and 36 had a diagnosis of chorioadenoma destruens or other related forms of trophoblastic disease which had metastasized. We have previously described in detail our treatment regimens and our general methods of management of the clinical and toxicological problems involved.[1, 7-10] We have also set forth our criteria for the evaluation of therapeutic response. These have included objective evidence of regression of tumor as manifested by physical findings, serial x-ray studies, and most importantly, the urinary excretion of chorionic gonadotropin as determined by bioassay.[8]

Follow-up studies have included repeated physical examination, x-rays, and hormonal assays. Thus far, only one patient has been lost to follow-up. Moreover, all but 2 patients who have died have undergone postmortem examination.

Seventy-two, or 64%, of these 111 patients with metastatic trophoblastic disease have experienced a complete and sustained remission (Tables 1 and 2). Forty-five of these patients in remission had a histological diagnosis of metastatic choriocarcinoma and 27 presented with other forms of metastatic disease.

The duration of these remissions is indicated in Table 3. Six of these patients have been in remisison for over five years and 57 of them for more than one year.

We have observed relapses in only four instances in 76 patients with metastatic disease whom we had previously considered to be in remission. Three of these relapses occurred within the first three months following cessation of therapy and one at 11 months. Hence our experience supports the conclusion that once a patient fulfills our hormonal criteria for remission we can anticipate that this remission will be sustained in at least 95% of the cases. The dependability of this prognosis is determined by the accuracy and sensitivity of the hormonal assay applied. It should be emphasized that commonly employed pregnancy tests are not sufficiently sensitive to be useful for the reliable diagnosis of complete remission.

Among 87 patients treated initially with methotrexate only 2 failed to show a substan-

tial tumor regression and 45, or 51%, have experienced a complete and sustained remisison following methotrexate alone. Twenty-three patients who have exhibited incomplete remission following repeated courses of methotrexate and whose tumor presumably had become resistant to this drug were subsequently treated with Actinomycin D. Twelve have experienced a complete remission and the remainder showed varying degrees of response. Thus the successive use of methotrexate and Actinomycin D may be expected to yield a complete remission rate of 75 per cent as compared with an expected remission rate of 19 per cent or less in comparable cases without chemotherapy.

In a selected group of 13 cases initial therapy consisted of Actinomycin D and complete remission was observed in 7. Thus, although our experience with Actinomycin D as primary therapy is indeed limited, this form of initial therapy is of great value in those patients in whom such presenting findings as impairment of hepatic function would contraindicate therapy with methotrexate.

We have previously described the toxicity induced by these intensive regimens with the respective agents employed.[1, 7, 11] These toxic effects are quite well known by this time and will not be enumerated here. However, it should be stressed that in gravely ill and debilitated individuals and especially in those who have initial evidence of hepatic, renal or bone marrow impairment, these agents are to be applied only with a full recognition of the hazard of irreversible toxicity. In our entire experience we have encountered irreversible toxicity in 6 patients and drug toxicity must be considered to have contributed to their death. It is therefore appropriate to consider the hazard of the type of intensive chemotherapy we have employed as an acceptable risk in the clinical setting in which it has been used.

Our use of the other oncolytic agents has been limited to those patients in whom complete remission had not been achieved with the regimens already described. In this group our most extensive single experience has been with Vincaleukoblastine as previously reported in detail.[11] In addition we have utilized Cytoxan, HN_2, DON, 6-Mercaptopurine, and the combination of methotrexate, chlorambucil, and Actinomycin D applied by Li et al.[12, 13] In general, the results in this special group of far-advanced cases of relatively long-standing have not been gratifying. However, one such patient experienced complete remission following Vincaleukoblastine, two following combination therapy and one after combined chemotherapy followed by hysterectomy. Nevertheless, we regard our findings to date with these forms of therapy too limited to warrant any evaluation of the place of these modalities in the initial treatment of trophoblastic disease in women. However, it is clear that they may prove valuable even in the special circumstances in which we have employed them.

The favorable results in patients with metastatic trophoblastic disease has stimulated us to apply similar chemotherapeutic regimens in the primary treatment of women with nonmetastatic trophoblastic disease for whom the classical management has been immediate hysterectomy.[14] It seemed reasonable to anticipate that results of chemotherapy would prove superior to those previously obtained by surgery. In addition, the child-bearing function would be preserved. Moreover, with the availability of the gonadotropin titer as a sensitive indicator of residual trophoblastic tissue necessity for subsequent surgery following chemotherapy could be accurately evaluated.

We have thus far treated 38 women with nonmetastatic trophoblastic disease by primary chemotherapy instead of immediate hysterectomy. In six of these women the histological diagnosis from curettements was considered to be "consistent with choriocarcinoma." In 32 women, gonadotropin titers had remained persistently elevated for from one to 12 months following the usual management of hydatidiform mole. In four of the "choriocarcinoma" patients and in 31 of these complicated postmole patients, prompt and complete remission was observed following one to four courses of methotrexate. In the 2 nonresponsive patients with "choriocarcinoma" subsequent hysterectomy resulted in complete remission. In the one nonresponsive postmole patient whose disease had been present for a year prior to chemotherapy, disease has persisted following removal of the uterus which contained no apparent tumor tissue.

Thus, surgery with attendant loss of the child-bearing function, has been obviated in 35 of 38 patients with nonmetastatic trophoblastic disease. As of April 1964 these remissions have been sustained for from one to six years and five of these patients have completed normal pregnancies.

In evaluating these results in the complicated postmole patients one should not disregard the known spontaneous clearing of disease in an undetermined percentage of such cases. However, Delfs[15] and Brewer[16] report the occurrence of chorioadenoma destruens in about one-fifth and of choriocarcinoma in about one-fifth of such patients. Moreover, the regularity of the response and the minimal hazard of irreversible drug toxicity in these nondebilitated patients more than justify immediate chemotherapy in such cases.

We may conclude by saying that hydatidiform mole, chorioadenoma destruens, and choriocarcinoma are to be regarded as a continuous and merging spectrum of trophoblastic disease. This disease process may be eradicated or substantially suppressed by various chemotherapeutic modalities. The prompt application of diagnostic and chemotherapeutic procedures may obviate the necessity for irreversible surgery and, in time, should make the advanced form of metastatic trophoblastic disease even rarer than it is today.

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ANNOUNCEMENT

The National Foundation-March of Dimes is pleased to announce a new Birth Defects Reprint Series. The reprints are of articles which have appeared in scientific and medical literature published in the United States and abroad. The first group of reprints is ready for distribution and includes the following:

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Immediate Partial Gastrectomy for Perforated Duodenal Ulcer

By CHARLES MARKS, M.D., M.R.C.P., F.R.C.S., Milwaukee, Wisconsin

■ IN CONSIDERING the wisdom of immediate gastric resection for the perforated duodenal ulcer, it is important to identify the three main types of perforation.

1. *Acute perforation.* Acute peritonitis is always present but varies in degree with the extent and period of peritoneal contamination.

2. *Subacute perforation.* This is generally small in size, almost pinpoint, and frequently seals off rapidly and spontaneously.

a. Formes frustes. The symptoms of peritonitis present themselves early in the course of perforation but tend to be mild and subside rapidly.

b. Perforations not associated with the classical features of peritonitis or pneumoperitoneum but tend to seal off rapidly with a small localized subphrenic gas bubble or develop a small walled-off abscess.

3. *Chronic perforation.* This refers to a chronic duodenal ulcer which penetrates into adjacent organs such as the pancreas, liver, gallbladder, or transverse colon.

It is inevitable that in the treatment of any disease, accumulation of knowledge, clinical maturity, and personal experience will determine therapeutic approach. In accepting gastric resection as the cornerstone of surgical treatment of duodenal ulcer, this has been our operation of choice in patients suffering intractability, also in selective cases presenting with bleeding and where pyloric stenosis has complicated the disease.

In 1953 on the basis of accumulated experience and awareness of the literature in this field, it was decided to carry out immediate surgical resection in patients presenting with acute perforation who were known to have been suffering from chronic duodenal ulceration and whose intractability in itself had been an indication for surgery, the acute perforation becoming an urgent incident in the disease. In the 10 years since this concept was introduced into this writer's private surgical practice, 22 patients have undergone gastric resection with a follow-up of 2 to 10 years. In all cases a Polya-Hofmeister antecolic antiperistaltic Billroth II type of anastomosis was performed. In none of these was vagotomy added, as it was felt to be undesirable to open up the appropriate tissue planes. There was no operative mortality. One patient suffered an incisional hernia which was repaired satisfactorily 18 months later, while one patient developed a right subphrenic abscess requiring rib resection and drainage on the tenth day following gastrectomy with complete cure. The long-term results have been good. There have been no cases with ulcer recurrence and all the patients expressed the wish that they had understood the benefits of the operative procedure and had undergone the curative operation earlier. Despite the fact that this is a small series, nevertheless some of the lessons learned would justify a brief review of this form of treatment in selective cases as the optimal mode of therapy.

The principal forms of treatment available in the management of the acutely perforated duodenal ulcer are:

1. *The conservative or nonoperative regimen.* This includes bedrest, continuous gastric suction, intravenous fluid administration, antibiotics, and frequent radiographs of the abdomen to assess whether there is an increasing amount of subphrenic gas. This form of treatment was originally advocated by Wangensteen[1] for management of the doubtful case, for localized perforation admitted to hospital late with evidence of having sealed off, and in the poor risk patient. In 1948, Sangster[2] reported 40 patients treated in this manner, with a 10% mortality. Taylor[3] treated 101 patients by this non-

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operative regimen, with 11 deaths, while at about the same time, in 1951, Nuboer[4] performed immediate partial gastrectomy for perforation in 131 patients, with only 5 deaths. Over the years, with better pre- and postoperative management, with improved ancillaries of antibiotics, gastric suction and improved anesthesia, as well as early diagnosis of the type of perforation, there remains little place for the nonoperative treatment of perforated duodenal ulcer.

2. *Laparotomy with simple suture closure of the perforation.* There is little doubt that this procedure will find the greatest appeal as it is technically feasible by even the least experienced surgeon, while limitations of facility provide no hindrance to its performance at any time. This approach reflects the attitude of Graham,[5] who stated that, "the surgeon's sole responsibility is to save the patient. At this time he does not have the responsibility of curing the ulcer. Any operative procedure directed towards the cure of the ulcer is unsound, meddlesome and adds greatly to the mortality as well as to the morbidity." In keeping with this injunction, Bierring et al,[6] reported their results with 240 patients with perforated peptic ulcer. Two hundred and thirty-one of these cases were treated by simple closure, with 12.6% mortality, while the late results were further prejudiced by reoperation being required in half of these patients, with a further secondary mortality rate of 8.7%.

Kingsbury and Schilling[7] in reporting on their series of patients who were treated by simple closure of perforated duodenal ulcer, pointed out that 42% of their patients had severe recurrence of ulcer symptoms by the end of the first year, while this figure increased to 68% after a year. This emphasizes the fact that perforation of a chronic ulcer is but an incident in an ulcerative disease process which will require subsequent cure. This has led some surgeons to recommend emergency suture of the perforation and four to six weeks later to carry out an elective gastric resection. This approach has the disadvantage in that it exposes the patient to two operations, prolonged convalescence with increased risks of mortality, morbidity, and appropriate economic disadvantages. Thus, it seemed to us that emergency gastrectomy for perforation would be desirable if the mortality rate be not significantly higher than for elective gastrectomy, nor should the mortality rate exceed that for operative closure of the perforation.

3. *Immediate gastric resection.* Yudin[8] found it possible to perform a Billroth I type gastrectomy in 80% of all his patients with perforated peptic ulcer. By 1939, he had performed the procedure in 937 patients with an 8.9% mortality, while Nuboer had 5 deaths in his 131 patients treated by immediate partial gastrectomy. Auchinloss published his results in 13 patients who had been treated by emergency gastrectomy without mortality, and these improved results added to the writings of Bobbio,[9] Graves,[10] and Niess,[11] which led to the writer's adoption of this procedure in the appropriately selected cases.

Case Selection. If it can be demonstrated that emergency gastric resection is feasible in the appropriate patient suffering from chronic duodenal ulceration, who perforates acutely, without jeopardizing the patient's chance of recovery from the complications, and at the same time curing him of his ulcer, then the experienced gastric surgeon need not be swayed by conservative argument that it be wiser to do a small operation to save the patient's life than the extensive procedure. Naturally, each individual surgeon will need to be guided by his own capability and experience, as well as by his facilities, while careful attention will need to be paid to the individual patient's circumstance such as age, general condition, duration of past ulcer invalidism, type and site of perforation, duration of time between perforation and surgery, and the degree and extent of peritoneal contamination found at operation.

The indication for immediate gastrectomy in our first case was the fact that the patient perforated four days after completing his second four-week course of hospital treatment for chronic duodenal ulcer. Although we had considered that immediate gastric resection might be contraindicated in patients under 30 years of age, one of our patients in his twenties, having suffered his second perforation, proved the exception to this rule. At operation local features of ulcer chronicity were always sought for and were characterized by induration and deformity, which paralleled the previous clinical history and previous barium meal studies, so as to justify partial gastrectomy on its own merits. It had been considered that there would be a dis-

tinct relationship between the period of time elapsing between perforation and surgery on the one hand, and the degree and extent of peritoneal contamination on the other. However, with increasing experience, we extended our arbitrary acceptable time interval from 3 hours to 5, then 7, and on one occasion to 12 hours when we found that the time factor was not the only or main determinant, but that early sealing or an empty stomach could be equally important.

Plan of Management. In each of our 22 cases the patient was first seen by his personal physician, who in each case made or suspected the correct clinical diagnosis. The patient was immediately sent to the emergency department of the general hospital, where he was seen in consultation with his physician. Once the diagnosis had been confirmed on clinical grounds, a gastric tube was place in position and the stomach aspirated. Blood was drawn for grouping and crossmatching and for any laboratory data that might be thought necessary, e.g., serum amylase or serum electrolytes. Premedication was administered one hour before surgery and comprised 20 mg of omnopon and 0.4 mg of scopolamine. In those cases thought necessary, an erect abdominal x-ray film was taken on the way to the operating room, but the absence of subdiaphragmatic gas did not, in the presence of strong clinical presumption, invalidate our clinical diagnosis. All the patients had general anesthesia with thiopental sodium (Pentothal) induction, intravenous succinylcholine for relaxation, and were maintained on gas, oxygen and ether after intubation. An intravenous saline infusion was commenced in the operating room, and not more than a unit of blood was utilized in any case, as often as not no blood being administered.

The abdominal exploration was performed through an upper midline incision extending from xiphisternum to umbilicus. After opening the peritoneum the diagnosis was confirmed. In every case in this series the perforation was on the anterosuperior aspect of the first part of the duodenum, although exact localization has often been difficult because of gross scarring and distortion by previous chronic ulceration. Any free fluid was aspirated and sent for bacteriological culture and antibiotic sensitivity assay, but in none of our cases was there ever any recognizable food debris or gross contamination.

After mobilization of the stomach, it has always been found possible to dissect out the scarred duodenal ulcer which was clamped and the duodenum divided distal to the perforation. The transected duodenum has then been closed by a continuous layer of atraumatic 2–0 chromic catgut and oversewn by a layer of interrupted seromuscular 2–0 silk sutures. In every case we carried out a standard two-thirds gastric resection with formation of a lesser curve valve.

A two-layer antecolic antiperistaltic gastrojejunal reconstructive anastomosis has been fashioned with interrupted seromuscular silk and continuous atraumatic catgut for the mucosal anastomosis. After making sure that no fluid collection remained, the subhepatic space has been drained through a separate stab wound and the abdomen closed in layers, using continuous No. 1 chromic catgut reinforced with interrupted silk and continuous catgut closure for the anterior fascial sheath. Postoperative management included a seven-day course of penicillin and streptomycin, although tetracycline was used in the event of allergic reaction to the former.

Summary. Realization that acute perforation of a chronic duodenal ulcer may well be an incident in the disease complex logically reflects therapeutic scope for immediate gastric resection as a definitive procedure, that removes the source of pathology without requiring a preliminary closure of the perforation and subsequent curative surgery. It is emphasized that this is a form of treatment that cannot be generally recommended, but that in the hands of experienced gastric surgeons it is a logical and satisfactory mode of treatment. Far from increasing risks of mortality and morbidity, in fact it tends to reduce the period of hospitalization and convalescence as well as exposing the patient to only one operative procedure.

8700 West Wisconsin Avenue.

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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Drug Dosage

By ALBERT C. YARD, Ph.D., M.D.

Milwaukee, Wisconsin

■ SELECTING THE DOSAGE of drug to be used in treating any disorder is a problem which is often given quite limited attention and yet is of overwhelming importance. The most important single consideration bearing on this issue is the concept that no drug administered in a fixed number of milligrams will be effective in all patients. To assume that the same dose of drug can be given to each patient with equal chance of success is to deny the difference between patients and differences in conditions of usage. Because some order of magnitude is needed as an orientation to proper dosage, an average dose is stated by the United States Pharmacopoeia as part of the official description of each drug. This is selected on the basis of two guidelines—achieving the therapeutic objective and avoiding drug toxicity.

The milligram dosage of hypothetical drug A which is just the threshold amount effective in bringing about a definite observable therapeutic response can vary over a several-fold range. Assume that for all patients treated with drug A in a life-time of practice, information on the minimal effective dosage has been gathered. If the minimally effective dose were categorized in 50 milligram increments, and if the population of patients were normally distributed with respect to response to drug A, a pattern of response resembling that shown in Figure 1 would be obtained. In this example, the dose to which the largest number of patients responded was 350 milligrams. However, some individuals achieved the same effect at only 100 milligrams, others showed no effect until a 600 milligram dose was given. The average or mean minimally effective dose of drug A in this sample was also 350 milligrams. In a normally distributed population, about 66% of the members are included within the limits of one standard deviation above or below the mean. In the present example, that would include all patients who responded to drug A between the doses of 300 and 400 milligrams. About 95 per cent of patients treated with drug A would be expected to respond to a dosage falling within two standard deviations of the mean, in this case between 250 and 450 milligrams. Thus, even though most patients would respond to this hypothetical drug at some quantity near the average dose, one should not be surprised to find patients who are quite susceptible or resistant to any drug. One conclusion which may be drawn from this example is that therapeutic failures in patients receiving the average dose of a drug may simply mean that these people constitute the upper end of the dose-response relationship. It may be equally difficult to recognize that an individual who has an exceedingly high sensitivity is being treated with more drug than necessary. The patient treated with an average dose, for example, 350 milligrams when 100 milligrams would have been sufficient to produce the desired response, has received 3.5 times the dose needed, an encroachment of significant and possibly dangerous magnitude upon the margin of safety of the drug. For any given

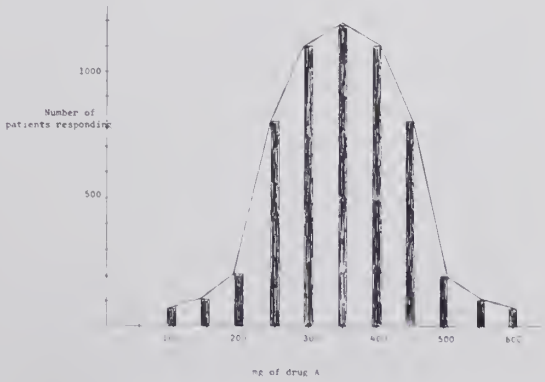

Figure 1

patient, of course, there is no way of knowing at the outset whether the dose required will be precisely the average, lower, or higher. The important thing is that constant observation of the patient is required to assess whether the drug is producing the desired response or not, and whether there are signs of toxicity which would suggest that the patient may be extraordinarily sensitive to a so-called average dose.

ADVISORY COMMITTEE REVIEWS MEDICAL ASSISTANT PROGRAM

The fastest-growing post-high school offering in the Sheboygan School of Vocational, Technical and Adult Education is the Medical Assistant Program. Twenty young women currently are enrolled in Medical Assistant classes designed to train them for positions in clinics, hospitals and doctors' offices. The school reports that 43 applications already are on file for next year's course.

The following advisory committee members scrutinized the young project Tuesday evening, March 23rd; Harris A. Weisse, M.D., Plymouth, Christopher Graf, M.D., Sheboygan, Vincent Meyer, Business Manager of the Sheboygan Clinic, Miss Alice L. Roelse, President-Elect, Wisconsin State Medical Assistants Society, and Mrs. Gladys S. Olsen, R.N., Kohler. Other committee members serving but not present Tuesday are James L. Jaeck, Pathologist at St. Nicholas Hospital, Mrs. Janet Graf, Sheboygan County Medical Auxiliary and William Nelson, Personnel Director of Memorial Hospital.

The advisory committee, formed when the program was initiated in 1962, was organized to assist school officials in gearing the instruction to practical demands of the position. The follow-up survey by Mrs. Georgette Johnson, teacher-supervisor of the

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from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

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Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

program, indicated that graduates of the classes of 1963 and 1964 were handling a variety of work situations, duties and responsibilities.

Arrangements are now being made to place the current enrollees in assistant positions for a two-week clinical experience before graduation in June. We are most anxious to have these students placed in doctor's offices immediately after graduation. Should any doctor have an opening in his office for a trained medical assistant, we would appreciate your contacting Mrs. Georgette Johnson, c/o Sheboygan School of Vocational, Technical and Adult Education, 843 Jefferson Avenue, Sheboygan, Wis. 53081. She will be very happy to recommend a medical assistant for your office. Transcript of records and references will be furnished upon request.—Alice L. Roelse, Chairman, Public Relations, Wisconsin State Medical Assistants Society

"KNOW THIS EMBLEM"

More than 110,000 persons are now wearing the Medic Alert Emblem. Distributed by the Medic Alert Foundation International, it carries on one side the Staff of Aesculapius and the words "Medic Alert" in red, while on the reverse side is engraved the immediate medical problem such as "diabetes," "allergic to penicillin," "taking anticoagulants," "wearing contact lenses," "neck breather," etc. Last year the Foundation voted to add the newly developed AMA symbol for emergency medical identification to the face of the Medic Alert Emblem.

The Medic Alert Foundation, a nonprofit organization, maintains a central file, accepting on a 24-hour basis collect calls from anywhere in the world and relaying information in the file pertaining to the wearer. Each emblem is registered and the serial number is engraved on the reverse side, as is the telephone number of the central file (209-634-4917). A percentage of each membership fee is placed in a special fund to help to perpetuate this service.

Further information and membership application forms may be secured by addressing Medic Alert Foundation, Turlock, Calif. 95380.—Reprinted from *Medical Annals of the District of Columbia*, 33: 341 (July) 1964.

EVIDENCE FOR "REBOUND" HYPERCOAGULABILITY AFTER STOPPING ANTICOAGULANTS

POLLER, L., AND THOMSON, J.—*Lancet*, 2:62 (July 11) 1964.

In many centers anticoagulant drugs are "tailed off" rather than stopped abruptly because of the clinical impression that "rebound" thrombosis may occur. In this investigation coagulability studies were performed on patients on long-term anticoagulant therapy and at weekly intervals after abrupt withdrawal of the drug. Tests were performed on 16 patients and on 6 healthy controls.

The results give evidence of rebound hypercoagulability seven days after stopping therapy. It appears to be due mainly to an increase of antihemophilic globulin (A.H.G., Factor VIII). "Raised levels of A.H.G. detected at the end of treatment fell toward normal much more slowly than did the factors depressed by anticoagulant recovery." Thus, the so-called "rebound" is more probably due to this overlap rather than any true rebound. It is concluded that after long-term anticoagulant therapy, the drugs should always be tailed off over a period of three to four weeks.—Reprinted from *International Medical Digest*, December 1964.

NEW HEALTH EDUCATIONAL BOOKLET

The mentally retarded girl, too, becomes a woman. At the first signs of adolescence, despite her mental age of perhaps four to eight years, she feels the same confusion, anguish and panic experienced by all girls.

Until now teachers and mothers of retarded girls have had no helpful aids to explain the changes occurring to these often confused, sometimes frightened youngsters.

A booklet just published by Kimberly-Clark Corporation fills the need for sensitive and sensible information on feminine hygiene for retarded girls. "How to tell the retarded girls about menstruation" is a simple explanation of the body changes that take place at adolescence and of the cleanliness that should be taught to every girl.

The booklet was prepared by Marion Jones, R.N., director of Kimberly-Clark's extensive public service program of providing information on health and feminine hygiene to millions of girls and women throughout the world. Its explanation can be adapted to the requirements and intellectual grasp of each mentally retarded girl, whether educable or trainable.

Copies of the free booklet are available from the Educational Department, Kimberly-Clark Corporation, Box 551-MRB, Neenah, Wisconsin.

MARKS REFERENCES *continued from page 196*

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THE NEW PRESIDENT

JOHN H. HOUGHTON, M.D.

Another native son of Wisconsin who is a general practitioner and surgeon took over the reins as president of the State Medical Society this month. He is Dr. John H. Houghton of Wisconsin Dells. Like his predecessor, Doctor Houghton has practiced in but one community—Wisconsin Dells—ever since he received his license in 1932. In civic affairs as well as in medical, he is a leader in that community.

Born Aug. 8, 1907, in Milwaukee, he received his medical education in that city at Marquette University School of Medicine, where he was granted his M.D. degree in 1932. From 1931 to 1932 he served an internship at Milwaukee County Hospital, and in 1936 he left his practice at Wisconsin Dells for a year's residency in surgery at St. Joseph's Hospital, Milwaukee. In 1937 he then went to University of Pennsylvania Postgraduate School of Medicine.

Doctor Houghton is associated with Drs. C. F. Broderick, F. W. Gissal, and H. L. Conley in the Dells Clinic. He is a member and present chief of staff at St. Mary s Ringling Bros. Hospital in Baraboo and a member of the staff at Divine Savior Hospital in Portage.

From 1950 through 1954 he served as delegate, and in 1950–1952 as president, of the Columbia–Marquette–Adams County Medical Society. Several appointments in the State Medical Society preceded his choice as president-elect. He served on a Special President's Committee on the Medical Care Survey, was councilor for the third district from 1956 until 1963, and was a member of the Commission on Medical Care Plans from 1961 until last spring, when he was named president-elect.

Doctor Houghton is married and the father of two children. Also a physician is his brother, Dr. W. J. Houghton of Milwaukee.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Threat to Public Health

■ WITH ALL THE URGENT problems facing the State of Wisconsin it would seem that the legislature has enough to do without lending itself to a deception of the public. Nevertheless, we are confronted with the astounding fact that the Assembly of the State of Wisconsin has voted that chiropractors, who are not doctors by any generally recognized academic degree, should be doctors by legislative fiat. After a two-week battle Assembly Bill 277 passed the Assembly and is now in the Senate.

By hook or by crook, the men of the chiropractic cult are determined to be doctors. The title has never been conferred on them by an accredited or scholastically recognized school of learning. It seems unlikely that most chiropractors could qualify for the degree by virtue of academic attainments. The dubious system of which they are practitioners is hardly the kind of serious, scientific learning that would merit the title in the first place. In fact, calling a member of the rib-tickling cult a doctor of chiropractic is like calling a bartender a doctor of mixology. It could be done only in jest.

Yet the Assembly has played just that grim joke on the people of our state. After previously vain attempts to earn their title legislatively, the cultists have mustered enough pressure to cross the first hurdle, and now the precious time of the Senate and the Governor must be wasted considering the errant and arrogant nonsense the chiropractors will present to support their demands. The problems of the state must wait while our solons occupy themselves with the business of the cultists.

But let no one be deceived that the quest of the legislated title on the part of the chiropractors is merely a conceit. If the legislature confers what no accredited American university would confer and allows the title of doctor to be used by chiropractors, it would do much more than expand the ego of that group who operate in a realm of pseudoscience. By enabling these cultists to call themselves doctors the legislature would blur the distinction between a legitimate, academically-conferred degree and the degree that is bought in some mail-order or store-front "school." And when the dignity and honor of a practitioner of a reputable science is so diluted that it can be assumed by a cultist, what sure guide will the victim of disease or injury have

Views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

left? How will the sick, who may be gullible or unsophisticated, keep out of the clutches of the charlatan masquerading with the title of a physician and surgeon, except after it is too late?

If allopathic or homeopathic physicians called themselves by another title, would the chiropractors be so eager to call themselves doctors? Would they spend so much money acquiring the right to use the title if it were used only by doctors of philosophy, legal jurisprudence, literature, divinity, or the like? Obviously not, for there is no money to be made in confusing those academic degrees. It is only for the sake of beguiling foolish patients who will pay for doubtful health care benefits that the chiropractors will spend their money to legislate themselves a degree. It is regrettable that the Assembly has made itself a party to their meretricious ambition.

The real point of this campaign by the chiropractic associations was recognized and dealt with almost 30 years ago by the Supreme Court of Wisconsin. Its opinion upheld the present statute which has the effect of forbidding chiropractors the right to use the title "doctor" and stated: "The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

It is not too late. The Senate and the Governor must concur. While we would have the government of our state devote itself to worthier projects, the merits of the matter must be thoroughly considered again. It is to be hoped that the integrity of the Senate and the wisdom of the Governor are superior to the designs of the chiropractors and that the side of professional integrity and scientific health care will be vindicated.—D. N. G.

GUEST EDITORIAL

Beneficial Coexistence

■ IN ALMOST EVERY state the number of people who, through no fault of their own, require governmental assistance for payment of medical expenses continues to increase. Certainly Wisconsin is not atypical, and each year the cost of providing medical care to welfare recipients rises. Involvement of the private practitioner with state welfare medical programs covering health care services therefore is inevitable, and this involvement requires close cooperation between the medical administrator of the program and the individual physician providing the health care services.

Obstacles to beneficial coexistence exist on both sides of the fence, but these are by no means insurmountable. The objective to provide completely adequate medical care for welfare recipients, and at the same time paying for these services within a framework of the usual and customary professonal charge should be agreed upon by all concerned. The mechanisms by which to achieve this goal need some consideration.

It is my belief that a minimum of restrictive controls to the practice of medicine by welfare departments brings the best result. I am sure this will hold true as long as there is a responsible force within the medical profession, but some controls and audit must be maintained to guard against possible abuse.

The concept of welfare departments paying the usual and customary charge for medical services is gathering momentum. Most officials administering welfare plans do not expect the local grocer or the landlord to bill less for their services or facilities for a welfare client, and there is no reason or justification to expect the medical practitioner to accept less than the usual and customary and reasonable fee for his services.

A disturbing factor to me is the practice of a small minority of the medical profession in charging higher rates to welfare departments than to their private pay patients for the same services. The explanation for this practice lies in the additional "paper work" involved. But this attitude is not in keeping with the concept and philosophy of a respected medical practice that puts a strong consideration on service.

To be sure, many medical programs administered by state agencies leave much to be desired as far as the private practitioner is concerned. Medical administrators of these programs, if they are worth their salt, recognize these inadequacies and will work hard to bring about suitable and acceptable adjustments. I realize that in any large scale program many factors come in for consideration. These programs cannot be changed

as easily as the private practitioner can change or correct an undesirable office routinue. Cost of the program in terms of dollars, federal requirements that must be met, opinions and decisions of state legislatures, and other factors all have to be dealt with so that the medical administrator is not the sole helmsman of his ship's destiny, but must often work with what he is handed.

I believe that with a responsible, socially conscious medical profession, giving them as free a hand as possible will result in the best and most economical plan of medical care. By implication this means that patients' visits to physicians will be done only when necessary in the best judgment of the physician, that patients will be hospitalized only when indicated, that the most suitable but least expensive drugs will be utilized, and over and under utilization becomes a thing we only talk about.

I realize that my philosophy may be idealistic, but if medical practitioners want a free profession and latitude to function relatively free of governmental control then they have the opportunity to demonstrate by their acts that they are practicing in good faith, that they can control their own mavericks and the unreasonable elements that tend to crop up. If this can be done then coexistence becomes a reality and everyone benefits.—JOHN ALLEN, M.D., Madison

Minutes of Council Meeting

MADISON, MARCH 13–14, 1965

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2 p.m. on Saturday, Mar. 13, 1965, at Society headquarters.

Voting members present were Doctors James, Schulz, Nordby, Davis, Stoops, Blanchard, Kief, Nadeau, Fox, Bell, Mason, Chojnacki (Sunday only), Hollenbeck, W. J. Houghton, Wright, Past President Egan, President Curran, and Speaker Callan. Others present were President-elect Houghton; Doctor Simenstad, AMA Trustee; Doctor Quisling, AMA Delegate; Doctors Bernhart and Galasinski, AMA Delegates (Saturday only); Doctors Tormey and Wunsch present for Commission on State Departments report; Messrs. Crownhart, Ragatz, Koenig, Reynolds, Maroney, Salt, Kluwin, Murphy (Sunday only), White; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Curran-James, carried, minutes of the December 1964 meeting were approved as distributed.

3. Council Award

On motion of Doctors Schulz-Curran, carried, the nomination made to the Council by letter from Doctor Fox was unanimously approved.

4. Honorary Membership

On motion of Doctors James-Nadeau, carried, M. G. Peterman, M.D., of Milwaukee, was elected to honorary membership on nomination of The Medical Society of Milwaukee County.

5. Scientific Fellow

On motion of Doctors Nordby-Stoops, carried, Alvin L. Berman, Ph.D., Assistant Professor of Anatomy at the University of Wisconsin, was granted the status of Scientific Fellow, the first to be so honored pursuant to the 1964 bylaw amendment.

6. Report of Commission on State Departments and Divisions

Doctors T. W. Tormey and C. A. Wunsch were present during review and discussion of the report of the Commission on State Departments and eight of its divisions, which had been sent to the Council following the March 7 meeting of the Commission.

The following division reports, on separate motion duly made, seconded and carried, were approved for transmittal to the House, including related fiscal notes attached to the report of the Commission itself:

A. Division on Aging
B. Division on Visual and Hearing Defects
C. Division on Maternal and Child Welfare
D. Division on Chest Diseases
E. Division on Handicapped Children
F. Division on School Health
G. Division on Safe Transportation

Doctor Wunsch spoke to the Council in support of recommendations of the Division on Nervous and Mental Diseases, contained in the report, that a separate commission or council be created for its activities, with direct reporting to the Council and House of Delegates; and that funds be allocated by the Society for a full-time staff man in this field, plus secretarial assistance and a travel budget. The fiscal note prepared by staff totaled $13,550 to implement proposals of this division, including $1,500 for postgraduate education programs.

In discussion, it was brought out that the division was perhaps not fully aware of all avenues now available to it for keeping abreast of activities, such as psychiatric representation on the Commission on Public Policy. There was also discussion of the impact on the dues structure of these proposals, which would require, in round figures, a $5 increase if other activities were not discontinued.

It was moved by Doctors Nordby-Blanchard, carried, that the report of the Division on Nervous and Mental Diseases be forwarded to the House with the

notation that the House consider it in recognition that it will involve a $5 dues increase.

Before adjournment of the Council on Sunday, Doctor Nordby moved for reconsideration of this action, seconded by Doctor Blanchard.

Their motion that the report be transmitted with the Council's disapproval recorded on removal of the division from the Commission and on special staffing carried 7–5 on a show of hands. It was requested that Doctor Wunsch be informed of this action and the reason that it would create a poor situation as far as other divisions are concerned.

On motion of Doctors Nadeau-Nordby, carried, the cover report of the Commission on State Departments was transmitted to the House, and Doctor Tormey was commended for his patience and diligence in acting as chairman of this Commission.

7. Community Achievement Award

On motion of Doctors Blanchard–Hollenbeck, carried, two hospitals nominated by the Commission on Hospital Relations and Medical Education were granted this award: Madison General Hospital, Madison, and Sacred Heart Hospital, Eau Claire.

8. Report on 1965 Wisconsin Work Week of Health

A report covering attendance, publicity, etc., on the Work Week of Health, was distributed to the Council. The week of February 14–18 was proposed for 1966, with the program so constructed that organizations cosponsoring a particular day will assist in promoting attendance by groups especially interested in a given topic.

On motion of Doctors Nordby–James, carried, the report was accepted with thanks and commendation to Mr. Reynolds and those who worked with him on another wonderful Work Week of Health.

9. Report of Committee on Economic Medicine

Doctor Nordby reported on the committee's review Saturday morning of proposed changes in the Provident disability program with a representative of Seefurth–McGiveran, insurance brokers. These require further negotiation with Provident, and involve increasing the weekly indemnity available; a longer waiting period option; inclusion of personnel such as clinic managers. The committee concurred with the refusal of Provident to offer a conversion policy when an enrollee leaves Wisconsin, and disapproved enrollment of students receiving loans from the CES Foundation as benefits would be payable only on permanent disability.

The committee also considered a low cost overhead expense group plan which would provide up to $1,500 per month after a thirty day period of continuous disability, with payment up to two years based on actual expense experience for a given period. It recommended this be approved in principle and made available to the membership.

Another new plan proposed by Seefurth–McGiveran was a group accidental death and dismemberment benefit available to a member and his wife if the spouse is not eligible as a member. The committee also approved this in principle for presentation to individual physicians.

The committee requested authority to take final action on changes in the Provident plan when additional information is available, so that it can be publicized to the members in advance of the annual meeting and information will be provided at an exhibit booth during the meeting.

On motion of Doctor Kief, seconded and carried, the report was accepted for implementation as requested.

10. Report of Finance Committee

In Doctor Dessloch's absence, Doctor Nordby reported on the February 20 meeting of the committee:

A. Executive Employment Contracts

The committee recommended that legal counsel prepare a model for further consideration—approved on motion of Doctors Nordby–Schulz, carried.

B. Physicians in Need

On motion of Doctors Nordby–Hollenbeck, carried, the following rules were approved as a guide to administration until such time as the committee of past presidents considers the matter further: (1) the grant of funds from the charitable account of the Foundation is not a gift but a loan on the possibility that there may later be assets with which to pay it, and because physicians seem to take more pride in a loan than a direct grant; and (2) that loans be approved by the trustee of the county in which the physician resides and by the councilor.

C. Index of Official Actions

On motion of Doctors Nordby–Blanchard, carried, the Council approved the recommendation that approximately $500 be approved to study how the project of a cumulative index can best be accomplished, probably on assignment to an independent contractor.

D. Pension Plan Investments

The Finance Committee, acting as trustees of the pension plan and on advice of investment counsel, increased the limitation on investments in common stocks from 40% to 60%.

On motion of Doctor Nordby, seconded and carried, this action was approved by the Council.

E. Executive Salaries

The committee's recommendations were discussed in executive session and approved as follows, it being customary to publish the salaries of the chief executives:

C. H. Crownhart, Secretary, annual salary increased from $30,000 to $35,000 (unchanged since 1958) and granted a $5,000 bonus. He was also voted tenure of office until retirement.

R. T. Ragatz, Assistant Secretary, annual part-time salary increased from $7,250 to $9,750 (unchanged since 1960).

R. E. Koenig, Insurance Director, salary increase from $22,500 to $25,000 effective May 1, 1965.

11. Report of Executive Committee

The following report of its March 12 meeting was presented by Doctor Curran, with action as indicated:

A. State Board of Medical Examiners

The Society is privileged to submit recommendations to the Governor for his consideration in making appointments to the State Board of Medical Examiners. Three terms expire this year.

On motion of Doctors James–Nadeau, carried, the slate of nominees proposed by the committee was approved.

B. Hospital Accreditation

A recent communication from the Wisconsin Hospital Association pointed out that Bill HR 1, currently being considered by Congress, provides that a hospital in order to participate in the hospital insurance program for the aged, must meet certain conditions and requirements as set forth in the bill or as developed by the Secretary of the Department of Health, Education and Welfare. A hospital will be deemed to meet the conditions of participation if it is accredited by the Joint Commission on Accreditation of Hospitals or provides the Secretary (of HEW) with reasonable assurance that any or all of the conditions have been met, if not accredited.

The Wisconsin Hospital Association inquired whether the State Medical Society would be willing to join with it and the Wisconsin Association of Medical Record Librarians in developing a number of teams to conduct an accreditation survey at the request of unaccredited hospitals in the state before a survey is done by the Joint Commission. There are some 66 such hospitals in the state.

The Executive Committee referred the matter to the Commission on Hospital Relations and Medical Education for exploration—approved by the Council on motion of Doctors Curran–Nordby.

C. National Health Legislation

The committee was made aware of another communication from the Wisconsin Hospital Association to its Institutional Members relative to proposals by the AMA and specialty societies to amend health care for the aged bills S 1 and HR 1 to remove payments for professional fees of pathologists, radiologists, anesthesiologists, and physiatrists. The bulletin states that "if these proposed amendments are adopted, it would mean that the professional fees for these specialists would not be considered as part of the hospital bill and so would not be paid under the program. This would create many problems for hospitals as well as for the aged covered under the program. The bill does not provide for the payment of any physician's fees and this would mean that the hospital would only be reimbursed for hospital charges which would not include professional fees. This would also mean that the aged in the program would have to pay separately the fees of the physician specialist. . . . This would also undoubtedly have a future effect on coverage of services which have traditionally been considered hospital services by Blue Cross and commercial insurance companies."

The member hospitals were asked to express opposition to these amendments to Representative Byrnes.

The Executive Committee reported this communication for information of the Council as to the position of the hospital association, and proposed to send the bulletin to the AMA for information and advice—approved on motion of Doctors Curran–Nordby.

D. Commission on Health Economics of American Life

The Council is aware of the difficulties that have been encountered in assembling in timely fashion the Commission on Health Economics of American Life, which was created several years ago to handle federal legislation. The Executive Committee recommended that for a trial period of a year it assume this function since a statement of the Society's position is often required on short notice and it would seem this could better be handled by a smaller group.

The recommendation was approved on motion of Doctors Curran–Nadeau.

E. Woman's Auxiliary

The committee considered two proposals by the current president of the Woman's Auxiliary, Mrs. John Satory of La Crosse. It approved the provision of an appropriate travelling trophy to be awarded annually to the county auxiliary showing the greatest increase in membership.

It cannot, however, approve the proposal that auxiliary dues be billed by the county medical societies. This would disrupt the established system of physicians' dues billings originating in the State Medical Society.

This portion of the report was approved on motion of Doctor Curran, seconded and carried.

F. May 1965 Council Meeting

The Executive Committee recommended that the normal schedule be retained of the Council meeting on Sunday before the 1965 annual meeting in Milwaukee so that adequate time is provided on Monday for preparation of supplementary reports to the House at the first session—approved on motion of Doctor Curran, seconded and carried.

G. 1966 Annual Meeting Schedule

The committee recommended for approval by the House the following schedule for the 1966 meeting in La Crosse to minimize conflicts with scientific and evening events: First session at noon on Monday, with reference committees meeting about three o'clock and concluding by dinner time; second and third sessions held consecutively beginning at three o'clock on Tuesday and concluding by six o'clock.

This recommendation was approved on motion of Doctor Curran, seconded and carried.

H. Maternal Mortality Survey

The Chairman of the Division on Maternal and Child Welfare, Doctor Evrard, had recommended that recognition be given to the three physicians who planned and have served continuously on the Maternal Mortality Survey since 1951, namely, Doctors T. A. Leonard, G. S. Kilkenny, and F. J. Hofmeister.

On motion of Doctors Curran–James, carried, the Council approved presentation of suitable recognition at the May meeting in Milwaukee.

12. Meeting with Officers of the Woman's Auxiliary

Mmes. J. J. Satory, W. D. James, F. H. Wolf, D. A. Hammes, and L. H. Edelblute joined the Council in general discussion of the aims and purposes of the Auxiliary.

A major goal is to increase membership and the ladies indicated that support from physicians in many areas is needed to encourage their wives to join the Auxiliary.

The Council was in general agreement that the Auxiliary should have no hesitancy to communicate this need to county society presidents. Doctor Kief suggested that the councilors be provided with information as to Auxiliary membership in each county.

The meeting was recessed at 5:10 p.m. and the Council reconvened at 9:50 a.m. on Sunday, March 14, as members of the SMS Realty Corporation, after which it resumed its agenda.

13. National Health Legislation

Mr. Murphy, supplemented by Doctors Simenstad, Bell and Nadeau, reported on recent contacts in Washington regarding the status of various legislative proposals on health care of the aged. No formal action was taken by the Council.

14. Further Report of Executive Committee

The Secretary reported several items for information or action from the February 20 meeting of the committee:

A. Presidential Citation

On motion of Doctors Nordby–Nadeau, carried, the Council approved the nomination by the President of the individual to receive the award in 1965.

B. Comments on Treatment Page—*Wisconsin Medical Journal*

On motion of Doctors Egan–James, carried, Ovid Meyer, M.D., was approved as co-editor for the University of Wisconsin.

C. Report on Income Tax Review

The Council was advised that tax counsel for national Blue Shield in Washington, D. C., will make inquiry into the status of the Society's pending assessment case in respect to the operation of WPS.

15. Report of Executive Committee of the Foundation

The following recommendations of the Executive Committee of the CES Foundation from its meeting Saturday morning were presented for Council action:

A. Non-medical Trustees

There is provision for ten trustees who are not physicians, and five have been elected by the Council. Mr. Earl R. Thayer and Mr. Stephen E. Gavin, Jr., were recommended for Council election.

B. Director of the Foundation

Mr. Norman J. Salt was recommended for assignment virtually full time in direction of affairs of the Foundation, while retaining supervision of the building and properties of the Society and divisions.

On motion of Doctors Chojnacki–Nordby, carried, these recommendations were approved.

16. Report of Commission on Public Policy

Mr. Maroney presented a report on behalf of Doctor Zach, chairman, of current state legislative proposals of interest to medicine, and the position taken by the Commission.

On motion of Doctors Nordby–Schulz, carried, the report was accepted.

The report is not included in these minutes since it will serve as the basis of the Commission's report to the House of Delegates together with later information on state legislation.

17. Report by Associate General Counsel

Mr. Kluwin reported for information of the Council on a Wisconsin decision involving the doctrine of "res ipsa loquitur" in a professional liability case.

He also reported on his participation in the hearing on a proposed Supreme Court rule with respect to impartial medical testimony. The great majority of appearances at the hearing were in opposition to the proposal, and Mr. Kluwin had taken the position that if the decision was to go ahead, it be laid over until fall for further hearing and opportunity for medical representatives to appear regarding its implementation.

18. Election of Officers

On motion of Doctors Egan–Blanchard, carried, the rules of the Council were suspended and elections laid over to the meeting following adjournment of the House in May.

19. Physicians in State Service

On motion of Doctors Nordby–Wright, carried, the Secretary was authorized to work with the President and President-elect on a statement to the Legislature in support of a realistic salary schedule for physicians in state service.

20. Adjournment

The meeting adjourned at 12:45 p.m.

C. H. Crownhart
Secretary

Approved:

James C. Fox, M.D.
Chairman

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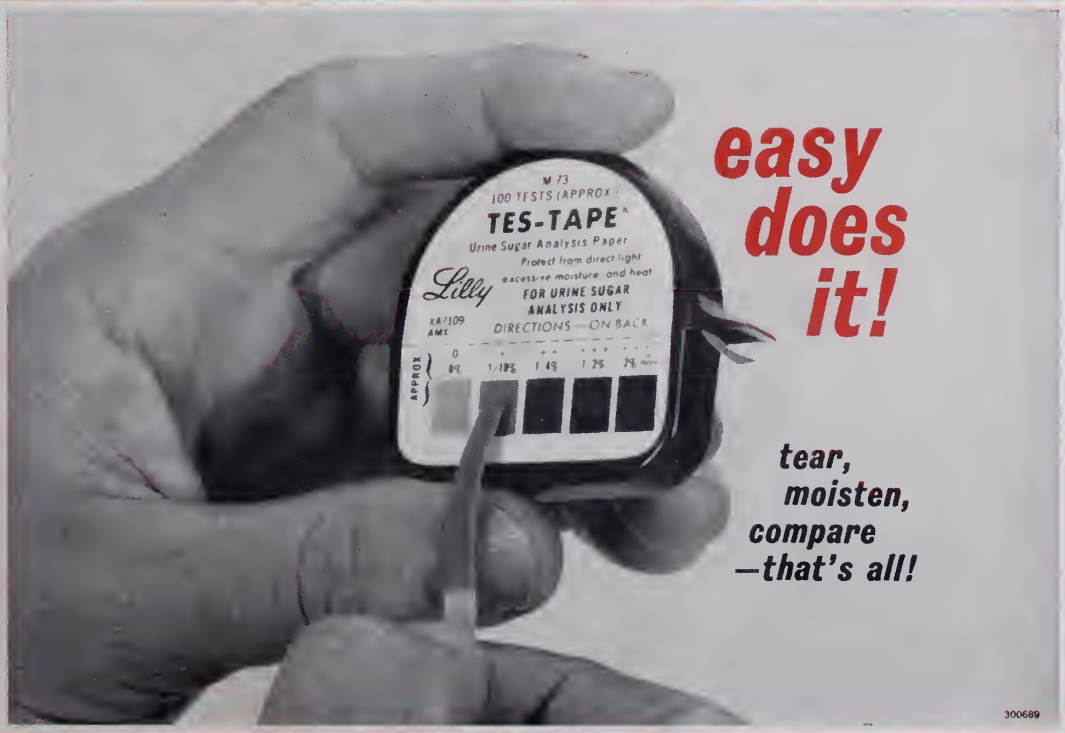

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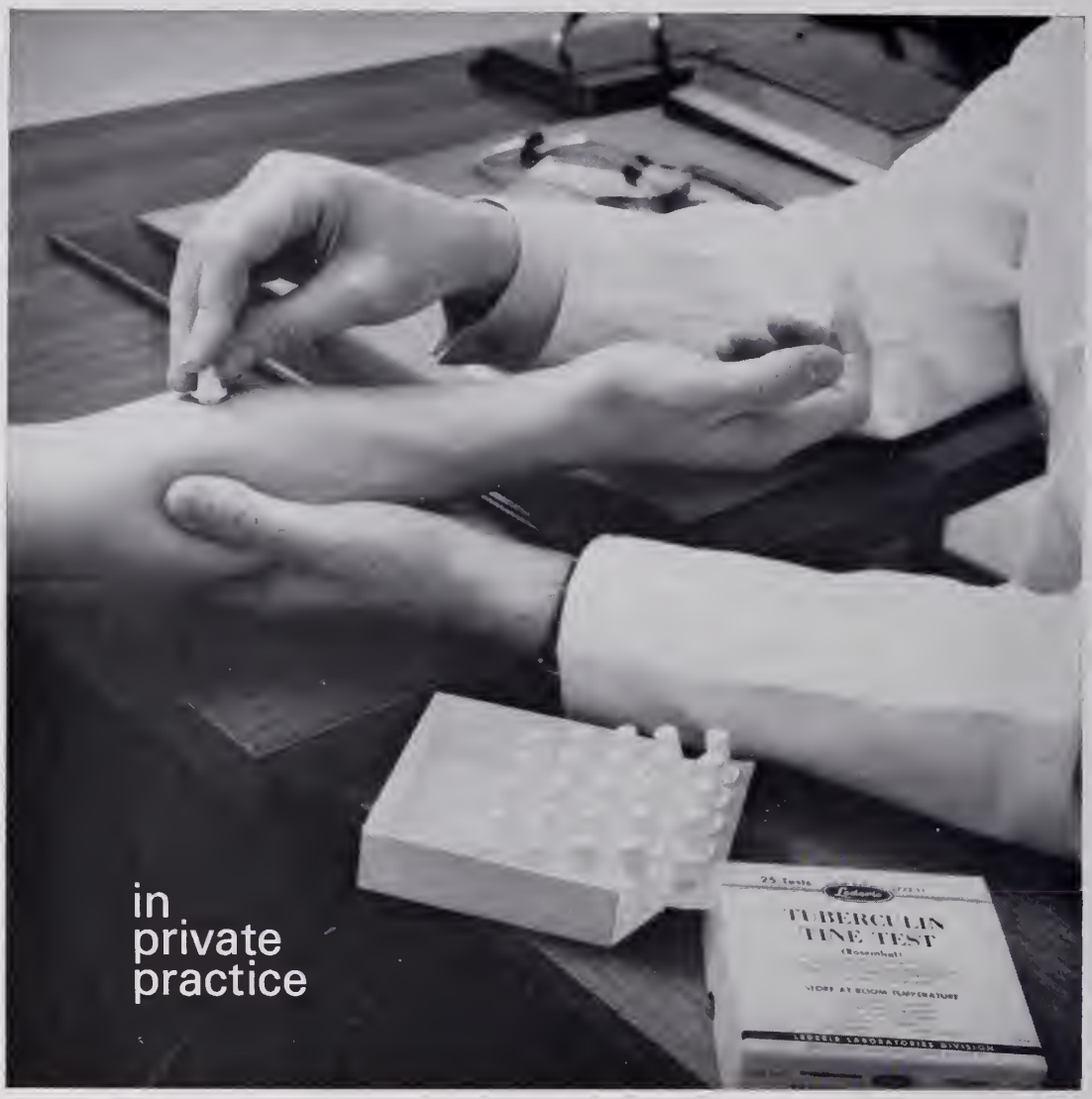

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BARRON-WASHBURN-SAWYER-BURNETT

Mr. Harris Romerien, director of distribution for the Red Cross Regional Blood Center, St. Paul. Minn., was the speaker for the April 13 meeting of the Barron-Washburn-Sawyer-Burnett County Medical Society. He discussed the working relationship and associated problems of the Blood Center and the hospitals and physicians of the four-county area.

During their business session, members approved a rheumatic fever clinic to be held in Rice Lake May 27, and agreed to review the Society constitution.

BROWN

An attendance of 47 marked the April 1 meeting of the Brown County Medical Society at De Pere.

Society president, *Dr. R. M. Waldkirch*, De Pere, asked for volunteers to employ, free of charge, girls graduating in June from the vocational school program for medical assistants. The girls were to be employed during May.

Society members voted their approval of the American Foundation for Psychiatry and Religion, an organization which handles applications from people seeking help in the field of mental health and trains ministers and other individuals to serve in this capacity. Mr. George Kress, a member of the organization, had informed Doctor Waldkirch that such a man is available for work in Green Bay, and he requested that one physician serve on the governing board. *Dr. E. R. Killeen*, Green Bay, was tentatively appointed.

At their March 11 meeting in Green Bay, the Society voted its approval of the Brown County Guidance Clinic's request to hire a pediatrician to examine children without a referring physician, or with special problems requiring detailed study, and in some cases, patients of limited means, unable to provide for their own medical care. Doctor Waldkirch appointed the five Green Bay pediatricians to select one of their number to serve in this capacity.

Dr. A. J. McCarey, Green Bay, was reappointed as the Charitable, Educational and Scientific Foundation trustee representing the Brown County Medical Society.

Dr. George Nadeau, Green Bay, reported on his trip to Washington with several other Wisconsin men for the purpose of assuring Rep. John Byrnes that the physicians of Wisconsin are sympathetic with his position in the current discussion of medical care for the aged.

CRAWFORD

The Crawford County Medical Society in cooperation with the Public Health Nursing Services sponsored smallpox vaccination clinics in April and early May at various schools in the county.

Physicians whose names appear in italics are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS

DANE

A program on "Normal Heart Muscle—Fundamentals of Structure and Functions" was presented at the meeting of the Dane County Medical Society May 11 at State Medical Society headquarters in Madison.

Speakers—all of them from the University of Wisconsin—were David B. Slautterback, Ph.D., assistant professor of anatomy, whose subject was "The Fine Structure of Cardiac Muscle (Electron Microscopy);" Larry D. Davis, Ph.D., assistant professor of physiology, "Mechanism of Rhythmisity of the Heart;" William B. Youmans, M.D., Ph.D., chairman, Department of Physiology, "Physiology of Heart Muscle—Including Review of Starling's Law;" and *Dr. George G. Rowe*, associate professor of medicine, Department of Medicine, "Biochemistry of Heart Muscles."

New members of the Society are *Drs. T. A. Schimanek*, *David T. Uehling* and *Richard L. Wesenberg*, and *Alvin L. Berman, Ph.D.* A native of Poland who received his medical education in Poland and Budapest, Hungary, Doctor Schimanek is currently a staff physician and assistant clinical director at Central Colony and Training School. Doctor Uehling was born at Evanston, Ill., and graduated in 1959 from Northwestern University Medical School. He is now an instructor in the Department of Surgery at University Hospitals. Doctor Wesenberg was born at Fond du Lac and received his medical training at the University of Wisconsin Medical School, where he graduated in 1962. He is in resident training in radiology at University Hospitals. A native of Baltimore who received the degree of Ph.D. in physiology at Johns Hopkins University in 1957, Doctor Berman is now an associate professor of anatomy at the University of Wisconsin Medical School. He is the Society's first "Scientific Fellow" member.

On June 27, the Society is chartering a special Milwaukee Road train for a trip to Prairie du Chien for tours of the Villa Louis, The Museum of Medical Progress, and Stovall Hall of Health. The excursion will also include a brief voyage on the "Prairie Gal," one of the last of the old Mississippi sternwheelers, to Indian Isle Restaurant for a buffet luncheon.

DOUGLAS

At a meeting held April 7 in Superior, members of the Douglas County Medical Society voted to officially endorse the program of activities carried on

by a newly organized group of Superior high school students who are working at a center for mentally retarded children. The Society's action was taken following talks by Barbara Sambraski and Nancy Nemec, the group's president and vice-president.

Dr. Milton Finn, Superior, reported on pending legislation on the Kerr-Mills act and changes in coverage by the Wisconsin Physicians Service.

Members voted adoption of two resolutions proposed by *Dr. C. J. Picard*, Superior, member of the House of Delegates, one dealing with redistricting and appointment of a committee of 13 members, and the other in reference to the interim meeting of the State Medical Society.

GREEN LAKE-WAUSHARA

Use of the mechanical respirator in pre- and post-operative care of patients was discussed by *Dr. James H. Barbour* of University Hospitals, Madison, at the meeting of Green Lake-Waushara County Medical Society April 22 in Wautoma.

Dr. Kwoh Cheng Sun's transfer from the Barron-Washburn-Sawyer-Burnett County Medical Society was accepted. Formerly located at Siren, Doctor Sun is now at Wautoma.

Dr. G. G. Shields of Wisconsin Rapids was a guest at the meeting.

KENOSHA

The Kenosha County Medical Society presented a truck to the Kenosha Achievement Center in mid-April. The presentation was made by the Society president, *Dr. R. G. Welsch.*

RACINE

The Racine County Medical Society held a regular business meeting April 29 in Voight Auditorium, St. Luke's Hospital, Racine.

WALWORTH

Dr. R. C. Hickey, professor and chairman, Department of Surgery, University of Wisconsin Medical School, Madison, presented a lecture on "Neck Dissection for Head and Neck Tumors" at the April 15 meeting of the Walworth County Medical Society in Fontana. Wives and guests were present for the dinner meeting.

WAUPACA

Officers of the Waupaca County Medical Society for 1965 are: *Dr. Albert J. Gloss*, Fremont, president; *Dr. Harry S. Caskey*, Clintonville, vice-president, and *Dr. Lloyd P. Maasch*, Weyauwega, secretary-treasurer. They were elected at a meeting held April 30.

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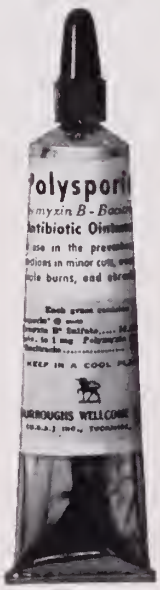

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SPECIALTY SOCIETY PROCEEDINGS

WHA, Fond du Lac Division

Dr. George A. Hellmuth, director of comprehensive and family medicine, Marquette University School of Medicine, Milwaukee, was keynote speaker at a "Cardiac-in-Industry" conference held April 21 at Fond du Lac under the sponsorship of the Wisconsin Heart Association, Fond du Lac Division, in cooperation with the Industrial Safety Council of the Fond du Lac Association of Commerce. *Dr. Jane Koll-Frazier*, Fond du Lac, served as chairman of the conference, which was the ninth in a series sponsored by the WHA.

Doctor Hellmuth spoke on "Heart Disease and the Law . . . a 10-year-study of the Wisconsin Industrial Commission."

Dr. Hugh J. McLane, Fond du Lac, WHA community service and education committee chairman, discussed the subject, "The Cardiac Can and Should Work," and also moderated a panel discussion. Among the other featured speakers were Clare D. Rejahl, Madison, rehabilitation consultant, and Catherine Chambers, RN, Madison, nursing consultant with the State Board of Health.

Dodge County Medical Assistants

During a tour of the new Medical Associates building in Beaver Dam, members of the Dodge County Medical Assistants Society heard an explanation on innovations in such factors as patient care, esthetic design, and communications.

The tour took place at the society's recent meeting, at which the program speaker was *Dr. William Funcke*, Beaver Dam. Doctor Funcke showed a film on the cause, development, and prevention of tetanus.

Decisions were made on several charitable projects during the business session conducted by Miss Sally LaFleur, president.

La Crosse Society for History of Medicine

At the quarterly meeting of the La Crosse Society for History of Medicine on April 29 at St. Francis Hospital, La Crosse, papers were presented by *Dr. Charles Skemp*, on "The History of Lithiasis," and *Dr. Albert Fisher*, on "The Pre-Freudian French School of Neuropsychiatry."

Milwaukee Oto-Ophthalmic Society

Medical and art illustrations by Michael Maradick were part of the program for the April 27 dinner meeting of the Milwaukee Oto-Ophthalmic Society at the University Club of Milwaukee.

State Medical Technologists

Workshops, and lectures and demonstrations on technical subjects, made up the working sessions of the spring convention of the Wisconsin Association of Medical Technologists Apr. 23–25 in Kenosha.

Workshops were held the first afternoon of the convention, with a board of directors meeting that evening. The following morning, members were welcomed by *Dr. S. H. Holt*, pathologist at Kenosha Memorial Hospital, and Stavri Joseph, M.T., president of the Association. Adding their words of welcome were Kenosha Mayor Eugene R. Hammond, *Dr. R. G. Welsch*, president of the Kenosha County Medical Society, and *Dr. R. J. Mayer*, president of the Racine County Medical Society.

Speakers included Ralph P. Jewell, M.T., chief medical technologist at Barberton Citizens' Hospital, Barberton, O., "Selected Aspects of Automation in the Clinical Laboratory;" Alvin Dubin, Ph.D., director of biochemistry, Cook County Hospital, Chicago, "Liver Function Tests in the Clinical Laboratory;" Charles Humes, vice-president of Coleman Instruments, Inc., Maywood, Ill., "Colorimetry;" *Dr. A. Yale Gerol*, Kenosha neurosurgeon, "Spinal Fluid Chemistry;" *Dr. J. C. Fralich*, Racine, "Amniocentesis in the RH Disease of the Newborn;" Lester W. Wells, Ph.D., biochemist at Kenosha Memorial Hospital, "Enzyme Chemistry;" *Dr. V. M. Miller*, thoracic and vascular surgeon, Racine, "Cigarets: Common Health Hazard."

Miss Florence Griswold, chief medical technologist at Madison General Hospital, was one of the participants in a panel discussion on purchasing.

Wisconsin Valley Chapter, AAGP

Four afternoon seminars for members of the Wisconsin Valley Chapter, American Academy of General Practice, were held at Sheboygan in March under the cosponsorship of the Wisconsin Valley Chapter, Wisconsin Academy of General Practice, and the State Medical Society of Wisconsin.

At each session, faculty members of the University of Wisconsin Medical School reviewed the latest medical developments of special interest to physicians and surgeons engaged in general practice.

Wisconsin Surgical Society

Dr. R. P. Sinaiko, Madison, was named president-elect of the Wisconsin Surgical Society at the group's 20th annual meeting the first week in May at Milwaukee. *Dr. Irwin Schulz*, Milwaukee, is the Society's president succeeding *Dr. N. O. Becker* of Fond du Lac, who presided over the meeting. *Dr. J. T. Mendenhall*, Madison, was reelected secretary–treasurer.

Speaker at the meeting was Dr. Alton Ochsner, founder and director of the Ochsner Clinic in New Orleans, La., who was presented with a certificate of honorary membership.

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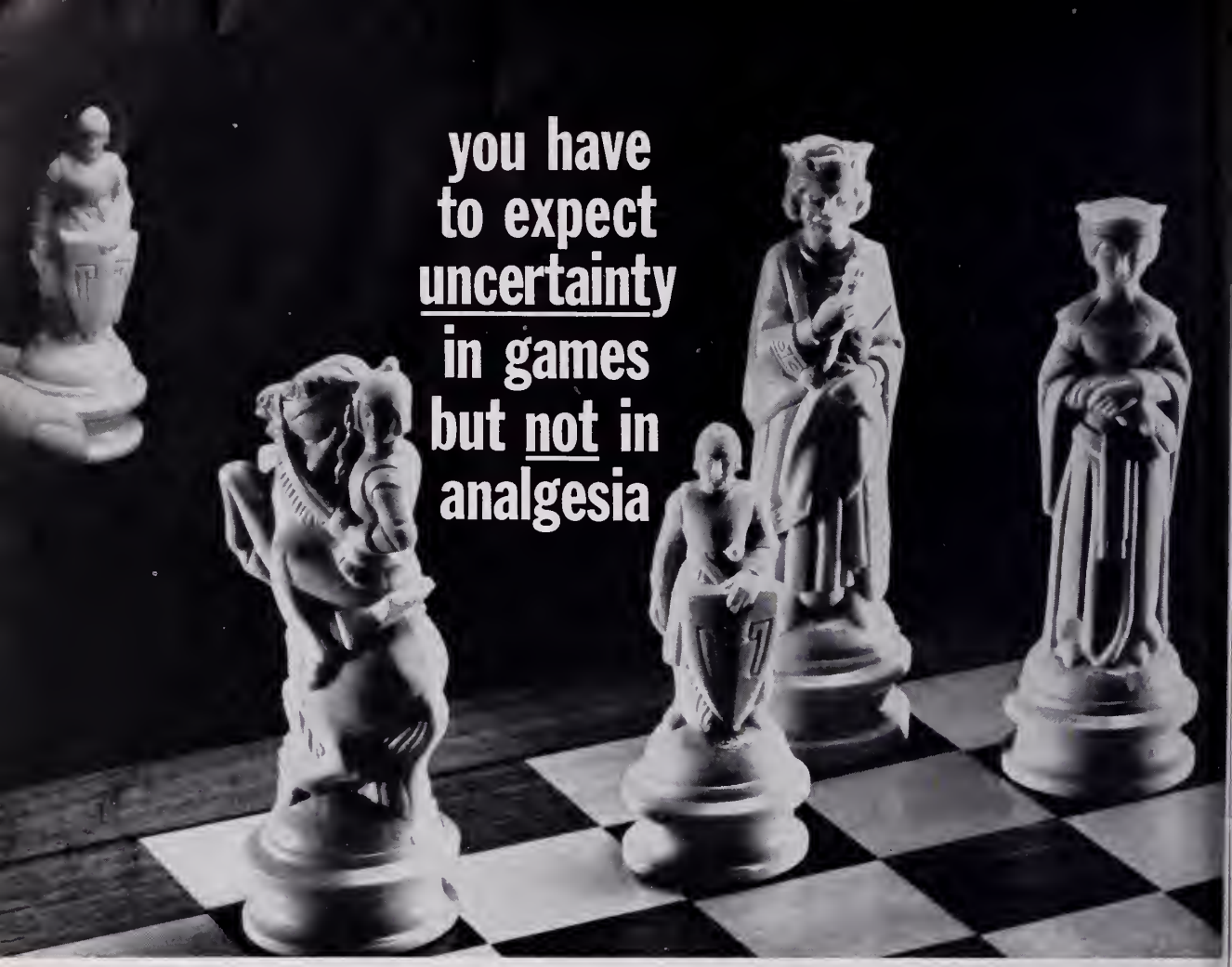

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NEWS OF WISCONSIN PHYSICIANS

Dr. Unger Heads Radiology Staff

Dr. June DeBoer Unger, Elm Grove, a staff radiologist since 1962, has been named chief of the radiology service at the Veterans Administration Hospital at Wood, the first woman to hold the post. Her husband, *Dr. George F. Unger*, also a radiologist, is a consultant at Wood.

Dr. Gott Leaves UW

Dr. Vincent L. Gott, member of the University of Wisconsin Medical School faculty since 1960, and the developer with Ronald L. Daggett, mechanical engineer, of the Gott-Daggett artificial heart valve, left Madison in mid-June for a post as head of the cardiac surgery service at Johns Hopkins University, Baltimore, Md. He starts work there July 1.

A 1953 graduate of Yale Medical School, Doctor Gott received the American Medical Association Hekteon Gold Medal in 1957, and in 1962 was named the John and Mary R. Markle scholar in academic medicine. At Johns Hopkins he will be in charge of all heart surgery and cardiac surgery research.

Dr. Santos Honored

Dr. G. P. Santos, anesthesiologist at Appleton Memorial Hospital since 1962, was honored by hospital employes at a party after he received his American citizenship papers this spring in proceedings at Green Bay. Doctor Santos is a native of the Philippines.

Dr. Ida Hunt 90

Dr. Ida Hunt, who at the turn of the century entered a select circle by becoming a woman physician, on April 9 entered another select group, that of the nonagenarians. A native of St. Louis, Mo., Doctor Hunt joined her physician husband in his practice at Boyd following her graduation in 1898 from St. Louis University School of Medicine. From Boyd the couple moved to Weyauwega where they practiced for more than 30 years. Doctor Hunt still owns an office-residence there but since June 1961 she has resided at the Dickson Rest Home at Fremont, where her husband died two years ago.

Dr. Knight UW Instructor

Dr. Curtis C. Knight has been appointed instructor in anesthesiology at the University of Wisconsin Medical School, Madison. He received his M.D. degree in 1956 from the University and for the past year was a resident in medicine at the Veterans Administration Hospital in Madison. He served his anesthesiology residency at University Hospitals and at Children's Hospital of Los Angeles.

Brillion Welcomes Dr. de Arteaga

Open house April 24 and 25 at the new $90,000 Brillion Clinic provided an opportunity for area residents to meet their first resident physician in nearly two years, Dr. Julio de Arteaga. Doctor de Arteaga and his wife and six children moved to Brillion early in April from their former home in Puerto Rico.

New Dean for University of Wisconsin

Dr. Peter L. Eichman, 39, member of the University of Wisconsin Medical School faculty for a decade and one of its administrators since 1962, was named dean of the School May 7 by University regents. He was nominated for the position by UW Pres. Fred Harvey Harrington and Madison campus Chancellor Robben W. Fleming.

The position has been filled by acting deans since 1961 when Dean John Z. Bowers was relieved of the deanship by the regents. A nationwide search for a successor "led us back to our own faculty," Chancellor Fleming said, "where the best candidates were to be found."

Peter Eichman, M.D.

Doctor Eichman, born in Philadelphia Nov. 18, 1925, is the youngest dean in the Medical School's history. He came to Wisconsin from the Mayo Foundation as research assistant in 1954 and worked up the ranks to associate professor in the departments of medicine and neurology in 1962 when he also became director of student health. Last March he was named assistant dean for clinical affairs in the Medical School.

He was elected chief of hospital staff for 1963–64 by the members of the clinical faculty. His research has been in the fields of hepatitis, porphyria and neurology with Drs. Frances Graham and Harry Waisman. He took part in some of the study of the relation of body chemicals to mental retardation in children. He also was a member of a research team on a six-year study of the effects of brain injury in children.

A 1945 graduate of St. Joseph's College, Philadelphia, he was awarded his M.D. degree by Jefferson Medical College, Philadelphia, in 1949, interned at Fitzgerald-Mercy Hospital, Lansdowne, Pa., and served residencies at Walter Reed Army Hospital, Jefferson Medical College, and the Mayo Founda-

Physicians whose names appear in italic are members of the State Medical Society.

tion. He has certification from the American Board of Psychiatry and Neurology and the American Board of Internal Medicine.

Doctor Eichman's leadership is credited for the recent major advances in the University student health service and he has been active in a wide variety of University faculty activities.

Dr. E. H. Jorris Is Named Wisconsin State Health Officer

Dr. E. H. Jorris (M.S.P.H.) was appointed State Health Officer by the Wisconsin State Board of Health May 21. Shortly after the action of the Board, Doctor Jorris filed his oath of office at the State Capitol. He succeeds *Dr. Carl N. Neupert* (M.S.P.H.) who has been State Health Officer since 1943.

Doctor Neupert had notified the Board of Health last October of his desire to step down this spring and the Board had named Doctor Jorris to become State Health Officer. Doctor Jorris is the fifth person to serve as State Health Officer since the Board of Health was created in March of 1876.

A native of La Crosse, Doctor Jorris received his early education in his home town and then earned his baccalaureate and doctor of medicine degrees at the University of Minnesota. After serving on the staff of the Nopeming Tuberculosis Sanitarium in Minnesota for 1 year and in private practice in Richland County, Wisconsin, for 5 years, he entered the field of public health in 1936 as district health officer for the State Board of Health in the office at Sparta.

Dr. E. H. Jorris

Dr. C. N. Neupert

In 1940, Doctor Jorris took his master's degree in public health at the University of Michigan. He returned to the central office of the Wisconsin State Board of Health as director of local health administration.

Commissioned a Commander in the medical corps of the Navy in 1943, he served 3 years during World War II. In 1946 he was appointed Assistant State Health Officer. He became a diplomate of the American Board of Preventive Medicine and Public Health in 1949.

Doctor Jorris is a member of the Dane County and State Medical Societies, and of the American Medical Association; a fellow of the American Public Health Association; past president of the Middle States Public Health Association, a member of the Wisconsin Association of Public Health, and of the Wisconsin Public Health Council. He is also a member of the Wisconsin Association of Public Health Physicians, the American Association of Public Health Physicians, and the American College of Preventive Medicine.

Doctor Neupert served as State Health Officer from 1943 and since the announcement last October of his approaching retirement, he has received many congratulatory letters and citations for meritorious service. Among these was the Award of Merit of the Wisconsin Hospital Association and the Council Award of the State Medical Society of Wisconsin, the highest award given by the Society.

Statement by Dr. Peter L. Eichman, Dean of the University of Wisconsin Medical School

"The Medical School at the University of Wisconsin has educated thousands of physicians over the years. In this regard and others it has established a fine tradition of service to the citizens of this state.

"During the last decade I have been privileged to assist this major educational endeavor as a teacher.

"My appointment to the Deanship will permit me to continue this service in a broader and more meaningful way. I welcome this opportunity and have a deep personal commitment to respond effectively to it.

"The University Medical Center is on the threshold of a major building program which should permit expansion and improved efficiency. The replacement of obsolete, scattered clinical facilities and the addition of research space for clinicians should result in the improvement and diversification of the clinical departments. The increase in laboratory facilities and teaching space in the basic sciences should encourage greater strength in an already strong sector of our school. It is especially important to the citizens of this state because we look toward increasing the number of physicians educated when our facilities are completed.

"The challenge to provide leadership to a strong and expanding school is a great one. I interpret the selection of one of our faculty as indicative of the confidence of the Board of Regents and the University administration in the school. I am sure that all of us on this faculty will strive to justify the trust and hope expresed in us."

Dr. Prouty Back from Himalayas

Dr. Margaret (Jo) Prouty and her companion, Miss Ruby Bere, both of Madison, returned home April 5 after an adventure high in the Himalayas. Undaunted by deep gorges bridged by a single log, they trekked the 175 miles from Katmandu, the capital of Nepal, to the base of Mt. Everest. There they were entertained by the second most important Buddhist lama. A veteran of mountain climbing in Peru, Africa, and Europe, Doctor Prouty negotiated for more than a year before she was able to

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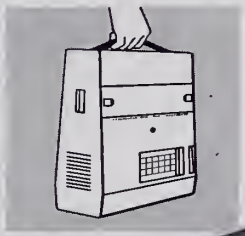

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PHYSICIAN NEWS *continued*

translate her dream of viewing Mt. Everest into reality. "This is Shangri-La," she said of isolated Nepal. "It's the most magnificent scenery I've ever seen."

Dr. Kelley at Winnebago

Dr. Thomas J. Kelley is the new clinical director at Winnebago State Hospital succeeding *Dr. H. Alfred Denzel*, who has returned to his native Germany on a research fellowship. A board certified psychiatrist, Doctor Kelley comes to Winnebago from the New Jersey State Hospital at Trenton, where he was assistant medical director.

Dr. Dorchester on Panel

Dr. Daniel E. Dorchester, Sturgeon Bay, a Door County physician and surgeon for 34 years, participated in a panel on "Tourism and Travel" at the April 22 meeting of the Madison Press Club. Doctor Dorchester is well known around the country because he flies his own plane to make distant house calls.

ACOG Elects Dr. Hofmeister

Dr. Frederick J. Hofmeister, Wauwatosa, was elected first vice-president of the American College of Obstetricians and Gynecologists at the group's annual clinical meeting April 4–8 in San Francisco.

One of several Wisconsin physicians installed as fellows of the College was *Dr. Chase W. Wolfe*, Milwaukee.

Dr. Niver at Eau Claire

Dr. Edwin O. Niver has joined the staff of the Northwest Psychiatric Clinic in Eau Claire, where he was engaged in private psychiatric practice from 1939 to 1953, except for five years in the U.S. Army. He is now associated with *Drs. A. A. Lorenz, J. M. Tobin*, and *E. R. Brousseau*. Doctor Niver practiced in Cleveland from 1953 to 1957, and subsequently was chief of the Division of Research and Education at the Mental Health Institute, Clarinda, Ia.

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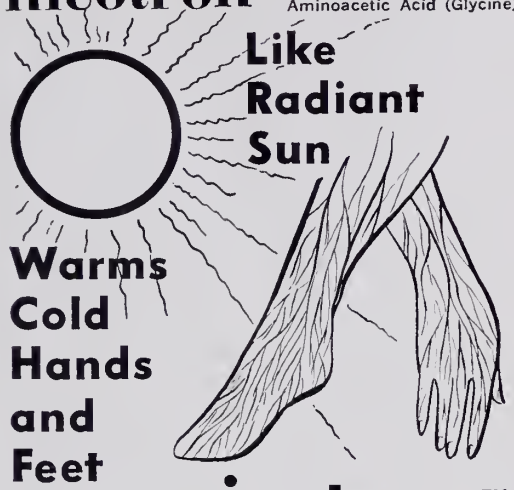

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Drs. Miller, Winter Aid with Clinic

When a second five-day clinic on how to stop smoking was offered by the Racine Health Fund the second week in May at Racine, *Dr. V. M. Miller*, Racine thoracic and vascular surgeon, opened the series with a discussion of the physical conditions linked with cigaret smoking, including lung cancer, chronic bronchitis, emphysema, and heart attacks. *Dr. B. V. Winter*, Union Grove, chairman of the health education committee and clinic co-chairman, probed the psychological and social reasons for smoking during the group therapy part of the clinic.

Doctor-Wife Duo Writes Guide

Dr. W. W. Bauer, former head of the Racine health department, and his wife, Florence Marvyne Bauer, have collaborated on a book, "Way to Womanhood," published in March by Doubleday & Company, Inc. Doctor and Mrs. Bauer now make their home in Chicago.

American Heritage

PUBLISHES EXCERPT FROM GALLAGHER MANUSCRIPT

The *American Heritage* magazine, June 1965 issue, has an article entitled, "A Yank in the B.E.F." This is an excerpt of a manuscript written by Dr. B. J. Gallagher of Waseca, Minn., in 1919 after he returned from the Great War. Doctor Gallagher, a Minnesota graduate (1916) was just finishing his internship at Minneapolis General Hospital when America entered the war against the Kaiser. He joined up and found himself assigned not to the American but to the British Army, along with some 1,300 other young American doctors.

Doctor Gallagher participated as a battalion medical officer in heavy fighting in late 1917 and early 1918. On Mar. 28, 1918, with the Allies in retreat before the last German "victory drive," he was cut off in his aid post and captured along with a group of wounded English soldiers.

His account of those days may be of interest to physicians of Viet Nam, Korea, and World War II vintage. Perhaps too there are some left of the "Lost Legion," as the 1,300 American doctors who served and suffered with our British allies long ago were dubbed —who will find this account interesting.

Doctor Gallagher, after a surgery fellowship at the Mayo Clinic, 1919–1922, practiced long and successfully in his home town of Waseca, Minn. He died in 1962 at home.

EDITOR'S NOTE: Our thanks to *Dr. William B. Gallagher* of La Crosse, for furnishing the Journal with the above information about his father.

Dr. Nereim Elected

Dr. T. J. Nereim, Madison, was elected a director of the American Academy of General Practice at the organization's annual meeting in April at San Francisco.

Dr. Headlee Promoted

Dr. Raymond Headlee, professor and acting chairman of the Department of Psychiatry, Marquette University School of Medicine, Milwaukee, has been promoted to the rank of medical director in the Reserve Corps of the United States Public Health Service. The rank is equivalent to full colonel in military services.

Dr. Burris Chosen

Dr. B. Cullen Burris, Milwaukee, has been named president-elect of the Milwaukee County Association for Mental Health.

Dr. Rammer Returns to Sheboygan

Dr. Martin A. Rammer, Jr., who on April 9 was released from active duty after more than 3½ years in the U.S. Army Medical Corps, has returned to his home town, Sheboygan, to engage in the general practice of medicine and surgery. He is a 1959 graduate of the University of Wisconsin Medical School.

Marquette Faculty Appointments

Faculty appointments recently announced at Marquette University School of Medicine, Milwaukee, include Drs. *John F. Imp*, instructor adjunct, Department of Psychiatry; Wei Y. Huang, research associate, Department of Gynecology and Obstetrics; M. Rosalie Hogan, clinical instructor, Department of Medicine; Norman M. Fisk, clinical instructor,

PHYSICIANS SPEAK AROUND THE STATE

Dr. M. A. Litton, pathologist at St. Mary's Hospital, Rhinelander, told Rhinelander Rotarians on April 12 that the family physician today is helped by a team of specialists which includes the pathologist.

Marshfield Clinic cardiologists, *Drs. Dean A. Emanuel, Richard D. Sautter*, and *George G. Griese*, at heart forum April 2 at Ladysmith.

Dr. Vincent L. Gott, Madison, lecture on "Advances in Cardiovascular Research and Open Heart Surgery," April 28 at Whitewater State University.

Dr. Robert J. Corliss, Madison, April 14 at the monthly medical staff meeting at Lakeland Hospital, Elkhorn.

Dr. G. G. Shields, Wisconsin Rapids, talk on "How It Looks to Your State Board of Health," March 31 at the Marathon County Rural Health Day in Marathon.

Department of Gynecology and Obstetrics; *Jordan N. Fink*, instructor, Department of Medicine; Robert L. Arends, associate, Department of Pediatrics; *George Wagner*, clinical instructor, Department of Pediatrics; George R. Kerby, instructor adjunct, Department of Medicine; Richard A. Collins and William Hays Card, assistant professors, Department of Pathology; *Saul F. Schwartz*, assistant clinical professor, Department of Gynecology and Obstetrics; *Peter F. Schatzki*, instructor, Department of Pathology; William J. Frable, assistant professor, Department of pathology; *Donald E. Chisholm*, clinical instructor, Department of Ophthalmology, and *Bruce J. Stoehr*, instructor, Department of Surgery.

State Medical Society Honors Fifteen Doctors For Fifty Years' Service

Fifteen Wisconsin physicians were honored by the State Medical Society of Wisconsin, Wednesday, May 5, when they were awarded memberships in the Society's "Fifty Year Club."

Completing 50 years of service to the medical profession and Wisconsin residents are: *Doctors C. H. Andrew*, Platteville; *W. E. Buckley*, Racine; *Homer M. Carter* and *R. T. Cooksey*, Madison; *Q. H. Danforth*, Oshkosh; *G. W. Huber*, Minocqua; *D. F. Hudek*, Bloomer; *M. L. Jones*, Wausau; *B. F. Kraus*, Sauk City; *J. D. Leahy*, Park Falls; *R. L. MacCornack, Sr.*, Whitehall; *E. O. Ravn*, Merrill; *J. E. Rueth, J. A. Fleischmann*, and *E. L. Tharinger*, all of Milwaukee.

With one exception they received their awards at the State Medical Society's annual dinner at the Hotel Schroeder, Milwaukee. Doctor Cooksey was presented his award earlier this year.

The doctors represent a total of 750 years of experience in the medical profession. Nine are general practitioners. The others are specialists in ophthalmology, pathology, surgery, and obstetrics and pediatrics.

All of the men, medical school graduates in 1915, were subject to service in World War I and three-fourths of them, upon graduation and finishing their internships saw service in the U. S. Medical Corps.

Doctor Andrew spent most of his life in medical practice in Platteville. In addition to serving his community as a physician, he has been active in many civic groups.

Federal Grants Approved for Hospital and Medical Facilities in Wisconsin

Seven projects calling for the allocation of federal grants-in-aid for hospital and medical facilities were approved in April by the Wisconsin State Board of Health. Included are three projects for the improvement of general hospitals, two for psychiatric units, and two for nursing homes. The estimated construction costs of these facilities would exceed $17,000,000; the federal grants would be $4,486,000.

General hospital units affected are at Oconomowoc, St. Croix Falls, and Wausau. At Oconomowoc the project calls for an addition of 42 beds to the present 48-bed Memorial Hospital. The St. Croix Falls Memorial Hospital improvement involves the addition of 19 beds, less four lost in the alteration work, for a net gain of 15 beds. At Wausau, St. Mary's Hospital will replace an old nonfire-resistive structure with 75 beds and central services.

Psychiatric units of general hospitals at Oshkosh and Waukesha will be provided under the program approved. At Mercy Hospital in Oshkosh the remodeling of a floor will provide a 25-bed psychiatric unit in the 296 bed general hospital. Memorial Hospital at Waukesha will construct an addition to house a 32-bed psychiatric unit; the hospital will have a total of 425 beds.

NEW EXHIBITS UNVEILED AT HEALTH MUSEUM OPENING

Machines for space and the human machine spotlighted the opening of the fifth season of the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien April 15.

The space display, provided by the National Aeronautics and Space Administration, traces progress from the first historic flight, through the recent Gemini success and into the planning stages of Project Apollo.

Project Apollo, as the exhibit illustrates, is a 3-man craft which is designed to attain lunar orbit and deposit two men on the moon.

"The exhibit is really complex," said curator Gordon Peckham, "including scale models of a number of the satellites and space capsules." A number of educational tours during the two months before school closing were expected with the NASA exhibit being the major attraction.

Another innovation for this year's opening is a special exhibit area holding an audience of about 50 people which will house semi-permanent exhibits, live demonstrations and lectures. For the Museum opening the "Transparent Twins," plastic, see-through, full-size models of the human body have been installed. Equipped with lights and sound, the twins give a basic course in physiology in 20 minutes. The "Twins" are on permanent loan from Wisconsin Physicians Service, the insurance division of the State Medical Society.

Approximately 50 other health exhibits were readied for the opening ceremony. The Museum, operated by the Charitable, Educational and Scientific Foundation of the State Medical Society, will remain open through October 31. Admission is $.75 for adults, $.15 for children with special group rates provided upon request.

A graduate of Marquette University School of Medicine, Doctor Buckley practiced in Hartford and Red Granite before settling in Racine, where he served as a president of the Racine County Medical Society and on a number of the society's committees.

A founding fellow of the American College of Obstetricians and Gynecologists, Doctor Carter was actively affiliated with St. Mary's Hospital and Madison General Hospital, served as president and secretary of the Dane County Medical Society, and conducted clinics in the use of drugs to prevent pain during childbirth.

A surgeon and leading member of the staff of Madison General Hospital in Madison, Doctor Cooksey, during his years of practice, was instrumental in initiating internship and residency programs for that hospital.

Doctor Danforth, Oshkosh, was educated at Marquette and maintained a special interest in ophthalmology throughout his medical career in Omro and Oshkosh. A member of the Winnebago County Medical Society and active in many civic affairs, Doctor Danforth is now retired.

Doctor Fleischmann, Milwaukee general practitioner, was born in Michigan and trained at Loyola in Chicago, interning at Lincoln, Neb., before settling in Milwaukee.

Another general practitioner, Doctor Huber, also trained at Loyola before settling in Minocqua. He is past president of Oneida–Vilas County Medical Society, was active as chairman of the Oneida County Board of Supervisors and treasurer of the Minocqua school board for 18 years. He retired in 1961.

Doctor Hudek, Bloomer general practitioner, was also active in civic affairs and voluntary health agencies. He received his training at Marquette and interned at Milwaukee County Hospital.

One of the preceptors for the University of Wisconsin Medical School, Doctor Jones, Wausau orthopedic surgeon, was not only active in teaching but held a number of positions in state and county medical society organizations. A graduate of Harvard Medical School, he spent his internship and residency in Boston before returning to Wausau to begin his practice.

A Sauk City general practitioner, Doctor Kraus was also educated at Loyola. He practiced in Madison and Sun Prairie before moving to Sauk City and has maintained his special interest and study in diseases of the eye during his years in medicine.

Doctor Leahy is still active in State Medical Society affairs. In addition to serving his state organization in many capacities, he was one of the founding officers of the Park Falls Hospital Association and a general practitioner in Park Falls since 1925.

Whitehall physician, Doctor MacCornack, has served as both speaker and vice-speaker of the House of Delegates for the Medical Society. Practicing in the community since 1919, he has written a health column for the WHITEHALL TIMES under the signature B. Well and has served in a number of civic capacities.

Doctor Ravn received his training at the University of Wisconsin and Northwestern University. After practicing in Iowa and serving in the first World War, he settled as the second of three generations of physicians in Merrill.

Maintaining his long special interest in arthritis and physical medicine, Doctor Reuth settled in Milwaukee after serving in World War I. A general practitioner who was educated at Marquette, he took his internship at Trinity Hospital and residency at Deaconess Hospital in Milwaukee.

Another Milwaukee physician, Doctor Tharinger, a pathologist, served as Milwaukee County's medical examiner from 1944 until 1954. He has also been active in Milwaukee County Medical Society affairs.

The awards were presented at the annual dinner by *Dr. W. P. Curran*, Antigo, the Society's outgoing president.

ADVANCED MATERNITY PROGRAM IN DELIVERY ROOM NURSING

Instructions in a unique and recently instituted course in maternity nursing at the Marquette University's College of Nursing at St. Joseph's Hospital, Milwaukee, are being offered state nurses. The course is being offered by Marquette's College of Nursing and the university's Division of Continuing Education under the sponsorship of the Wisconsin State Board of Health and operates on a grant from the board's Bureau of Maternal and Child Welfare.

Ten courses are offered each year with a maximum of four nurses to each two-week session. Nurses taking part are reimbursed for all costs. Each enrolee must have been graduated from an accredited nursing school and hold a current Wisconsin nursing registration permit.

All nurses must be sponsored by a physician. Director of the program, Miss Anita Grand, R.N., has stated that the course has been designed to meet the needs of two groups—nurses working in small hospitals that have no house staff or school of nursing and nurses who have been out of school for many years and now are returning to their profession.

The program runs for two weeks and the beginning dates are: Oct. 18, 1965; Nov. 8, 1965; Jan. 17, 1966; Feb. 14, 1966; Mar. 14, 1966; and Apr. 18, 1966. Applications or inquiries should be directed to Miss Anita Grand, R.N., Marquette University College of Nursing, 3029 N. 49th Street, Milwaukee, Wis. 53210.

Nurses desiring to attend are encouraged to apply early due to the limited number of programs being offered and the restriction to the number of participants in each program.

1965 **Wisconsin**

Aug. 23–28: Seminar on control procedures in drug production, Wisconsin Center, Madison.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Sept. 15: Wisconsin State Medical Golf Association, annual fall tournament, Janesville Country Club.

Sept. 25: 11th Annual Fall Cancer Conference, University of Wisconsin Medical Center, Madison.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

1965 **Out-of-State**

July 5–8: University of Colorado School of Medicine, post-graduate course in ophthalmology, Estes Park, Colo.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

July 16–17: 19th annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

July 18–24: 11th annual general practice review (repetition of January course), Denver, Colo.

July 26–30: Continuation course on cardiac arrhythmias, Hahnemann Medical College and Hospital, Philadelphia.

July 29: 2nd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology, Vienna, Austria.

Aug. 2–6: Department of Pediatrics and Office of Postgraduate Medical Education of University of Colorado School of Medicine, 8th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 4–15: American Physicians Fellowship, orthopedic seminar, under jurisdiction of Israel Medical Association, in Israel.

Aug. 8: 8th International Anatomical Congress, Wiesbaden, Germany.

Aug. 9–13: University of Colorado School of Medicine, post-graduate course in internal medicine, Estes Park, Colo.

Aug. 16–20: University of Colorado School of Medicine, medical audiology workshop, Estes Park, Colo.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30-Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15, 1965-June 15, 1966: Tutorial program in cardiology offered by Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16: Seventh International Congress of General Practice, Salzburg, Austria.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 11–13: Academy of Psychosomatic Medicine, annual meeting, Sherman House, Chicago. Joint morning meeting and luncheon Oct. 11 with American Society of Clinical Hypnosis.

Oct. 13: Department of Psychiatry and Neurology, Chicago Medical School, start of postgraduate courses in psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists.

Oct. 13–14: American Heart Association Council on Arteriosclerosis, annual meeting, Hotel Deauville, Bal Harbour, Fla.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Oct. 18–22: American College of Chest Physicians, postgraduate course No. 1, "Clinical Application of Cardiopulmonary Physiology," Knickerbocker Hotel, Chicago, Ill.

Oct. 28–30: American College of Gastroenterology, annual course in postgraduate gastroenterology, Americana Hotel, Bal Harbour, Fla.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30-Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–4: Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

Nov. 8–10: University of Colorado School of Medicine, postgraduate course, "The Hospital Medical Staff," Denver, Colo.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI meeting, Pick–Congress Hotel, Chicago, Ill.

Nov. 11–13: University of Colorado School of Medicine, postgraduate course, "Medical Education in the Hospital," Denver, Colo.

Nov. 15–19: American College of Chest Physicians, postgraduate course No. 2, "Diagnosis and Treatment of Diseases of Heart and Lungs," Barbizon Plaza Hotel, New York City.

Nov. 22–24: 15th Hahnemann Symposium, "Cancer Chemotherapy: Basic and Clinical Applications," sponsored by Department of Medicine, Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia 2, Pa.

Dec. 8–10: Hahnemann Symposium, "New Concepts in Gynecological Oncology," Sheraton Hotel, Philadelphia 2, Pa.

1966

Jan. 24–28: American College of Chest Physicians, postgraduate course No. 3, "What's New in Diagnosis and Treatment of Cardiovascular and Pulmonary Diseases," Fontainebleau Hotel, Miami Beach, Fla.

Feb. 14–18: American College of Chest Physicians, postgraduate course No. 4, "Clinical Application of Cardiopulmonary Physiology," Ambassador Hotel, Los Angeles, Calif.

June 26–July 2: 7th International Congress of Gerontology, Imperial Castle, Vienna, Austria.

Aug. 20–25: 9th International Congress on Diseases of Chest, sponsored by Council on International Affairs of American College of Chest Physicians, H. C. Orsted Institute, University of Copenhagen, Copenhagen, Denmark.

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

American Physicians Fellowship

The American Physicians Fellowship is sponsoring an orthopedic seminar, under the jurisdiction of the Israel Medical Association, to take place in Israel August 4–15. The seminar will be under the direction of Dr. Melvin J. Glimcher of Boston, associate professor of medicine at Harvard Medical School and director of Orthopedic Research Laboratories, Massachusetts General Hospital.

Members of the faculty will include doctors from the United States, Canada, France, Sweden, and Italy.

Registration fee for the seminar is $50. There will also be a tour which will include deluxe hotels, meals, sightseeing, and transfers. Inquiries and reservations should be directed to the American Physicians Fellowship, 1622 Beacon St., Brookline, Mass. 02146.

Drug Production Seminar

A Seminar on Control Procedures in Drug Production will be held at the Wisconsin Center in Madison the week of August 23. The University of Wisconsin School of Pharmacy and Extension Services in Pharmacy, the Pharmaceutical Manufacturers Association, and the Food and Drug Administration of the U.S. Department of Health, Education, and Welfare are cooperating to arrange the seminar, which will emphasize current good manufacturing practices in drug production and FDA's regulations in this area.

The faculty of Wisconsin's School of Pharmacy will conduct the Seminar with the assistance of outside lecturers to be selected by the cooperating groups. It will be open on an industry-wide basis to approximately 100 quality control and production supervisors of drug manufacturing firms who have a direct responsibility in assuring that drugs meet acceptable standards.

"The purpose of the Seminar is to bring together the best information available to FDA and the industry on quality control in drug production," said a joint statement issued by Dr. William L. Blockstein, chairman, Wisconsin's Extension Services in Pharmacy; Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, and Food and Drug Commissioner George P. Larrick.

Postgraduate Courses at Vienna, Austria

This year a new diversified program of postgraduate seminars has been issued by the American Medical Society of Vienna in connection with the Medical Faculty of the University of Vienna. Dr. M. A. Kline, the President of the Society, reports an extended schedule of seminars in all medical specialties and subspecialties and the availability of top medical scientists of the University Clinics.

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Medical seminars are arranged for any visiting doctors on an individual basis or for groups. The office of the Society at Universitaetsstrasse 11 at Vienna prepares a schedule of contacts with English-speaking faculty members of the University Clinics. Practical sessions, surgical operations, round table discussions and grand rounds are part of the seminars. Teaching lectures are not usually given. The time spent at these seminars, a few days or weeks, can be tailored to the individual need and a so-called Medical Congress letter is issued upon completion. Extended courses up to three and ten months are conducted and a diploma issued by the Medical Academy of Vienna.

The subjects especially favored by American doctors studying in Vienna are: Surgery and subspecialties, Gynecology, Ophthalmology, ENT, Urology and Dermatology. Time spent there under these auspices represents a bona fide medical continuation training and expenses incurred in connection with these seminars are deductible according to the IRS ruling. Detailed information can be obtained from the secretary of the Society at the above named address.

Furthermore 1965 is marked by the sixth centennial of the foundation of the University of Vienna. Festivities are planned by the Austrian government and the Regents of the University, culminating in a number of gala events in May 1965. The club headquarters of the Society will arrange all contacts and accommodations on request.

7th International Gerontology Congress

The Seventh International Congress of Gerontology will be held June 26–July 2, 1966, in Vienna, Austria, at the Vienna Hofburg (Imperial Castle). Main themes will be the role of environment in aging, adaptability in aging persons, methodology, research, and education in gerontology, current trends in gerontology, age, work, and social change, and problems of therapy in gerontology.

Special subjects of gerontology will deal with the fields of biological research, clinical medicine, psychology and social sciences, and social welfare.

The official languages will be English, French, and German, and simultaneous translation will be provided for these languages only.

Deadline for submission of papers for the main and special gerontological subjects is June 15, 1965; for open papers and abstracts, Dec. 15, 1965. Full length manuscripts, ready for printing, must arrive not later than March 1, 1966.

Registrations, inquiries, and submissions of manuscripts and abstracts should be addressed to: SEKRETARIAT, 7. Internationaler Kongress für Gerontologie (Mrs. Ingrid Andersons), Wiener Medizinische Akademie, Alser Strasse 4, Vienna IX, Austria. Telephone 42 04 19.

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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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the wisconsin medical journal

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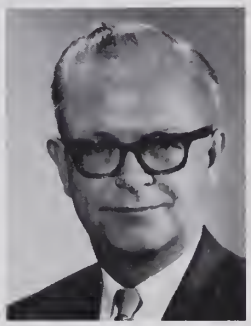
President's Message to the House of Delegates



By J. H. HOUGHTON, M.D., Wisconsin Dells, Wisconsin

■ ONE YEAR AGO I stood here as president-elect and promised to serve you to the best of my ability. This has been a most interesting year. Much has transpired nationally and locally. We have Kerr-Mills in the state and we are faced with Medicare. I thought that I had been quite active in State Medical Society affairs over the past several years, but this past year I discovered that I had merely scratched the surface. Let me tell you that your S.M.S. is a BIG organization. Let me also tell you that its primary function is to serve the health needs of the public.

We have many committees in our Society. These evolve from the House of Delegates and from the Council. The incoming president has the privilege of making appointments to certain committees after consultation with the Council. In addition, there are two wholly-owned subsidiary corporations —the SMS Realty Corporation and the CES Foundation. In all, there are 54 committees and commissions. It is impossible for any practicing physician to attend all meetings of all committees. Let me assure you, however, that I have attended as many as I possibly could, and I might add that your Society has had excellent leadership during the past year under President Curran.

Presented before the House of Delegates at the 124th annual meeting of the State Medical Society, May 3, 1965, Milwaukee.

What can we expect of 1965–66? We have much for which to prepare. If Medicare becomes a law—and it looks like it will—and comes into actual being July 1, 1966, how are we going to handle this? We will be faced with a new way of Medicine for at least a segment of our population—those 65 and over. We were not consulted about this new law, and, in fact, it was created over our strenuous opposition, but we're going to have to live with it. And not only are we going to have to live with it, we're going to have to police it. Who determines when an individual has to be hospitalized? Who determines when a hospital patient is to be discharged? If the program turns out to cost more than the social planners estimated, who's going to be blamed? The answer to all three questions is the same—you and I and all the practicing physicians in the country. What can we do about it? The only thing we can do, in all good conscience, is to try to give the American people the same caliber of medical care to which they have been accustomed under the free enterprise system. Times change, and we must try to adjust to them, in spite of our disagreement with some of the changes.

What else needs to be done? We have a very active committee in our Commission on Public Policy. Every year there are bills introduced in our State Legislature that per-

tain to Medicine. It is my belief that this Commission should be bipartisan, or, if you will, nonpartisan, so that it may speak to all our legislators on behalf of Medicine to safeguard the health of our citizens. There are many ancillary groups who are trying to legislate themselves into activities for which they do not have the proper training. This is a continuing problem and one which must be scrutinized constantly by dedicated men who have the well-being of the public at heart.

Our CES Foundation is a growing infant. It has many functions among which are programs of medical history in the State, continuing education for the practicing physician, medical student loans, and perhaps financial help to needy physicians. This last function deserves a little more consideration. Some years back the Council authorized maintenance of an aid fund from the dues structure at a level of $1,000, but experience has shown this to be inadequate. At times it has been necessary to supplement this fund from uncommitted donations. To some of us, this is a sad state of affairs. Industry takes care of its own; Labor takes care of its own. What are we doing to take care of our men who have devoted their lives to the services of mankind, only to find near the trail's end, or sooner, that they cannot adequately provide for themselves or their families? At the present time this problem has been given to the Special Committee of Past Presidents, but they need the help of all the members of this Society to determine the need, and to recommend details of a plan to provide for all hardship cases among physicians, including the mechanism for raising funds for such a project.

A commission of which we can all be justly proud is our Commission on Medical Care Plans. I am particularly referring to WPS, the Blue Shield Plan of our State Society. We, and I say "we" because this is our plan, had a tremendous year in 1964, showing an increase of 16 per cent in premium dollars and 10 per cent contract growth over 1963. Every member of this Society should continue to promote our medical-surgical-hospital plan because we believe it to be the best protection that can be offered to the public. Through our pioneering of the "no fee schedule" concept, our Special Service contract, we are beginning to attract national attention and acquiescence to the feasibility of this approach. Much of the credit for this must be given to our Secretary, our Actuary, our past and present Insurance Directors and to the Chairman and others of our Commission.

This past year also saw the initiation of a so-called Town and Gown Symposium. We, as a State Medical Society, must take some responsibility in medical education. There is no reason, in my mind, why medical educators and practicing physicians should not communicate with each other. It is possible that much good can come from this, not only to the educators and the practicing MDs but also to the public. I hope that the program started this year will be but a start for better and more well attended meetings in the future.

To get back to Medicare. Perhaps this Federal legislation provides us with one of the greatest opportunities Medicine and free enterprise has ever had. While it is fairly broad in scope, it still does not cover the cases about which many men worry. I have had patients tell me that they do not worry about the limited expenses of medical and hospital care, but they are concerned about the prolonged illnesses that could eat up an estate. This may be the time to offer a type of insurance that has the utmost in deductibility. The actuaries can determine this. But here you have deductibles of 60 days hospital, and/or nursing home care, plus payment of 80 per cent of other expenses up to a certain amount. What happens then? The individual has to use up his principal to pay for expenses over and above this in a case of prolonged illness requiring, perhaps for life, hospital or nursing home care.

Why couldn't we write a policy for those 65 and over to cover the expenses of a prolonged illness when the help provided by current Federal legislation runs out? The cost of such insurance should be nominal, but the peace of mind it would afford purchasers could be great.

What else can we do, as physicians, to combat creeping Socialism in this Country? And make no mistake about it, Medicare is only a step in this direction. The selling of Medicare can be compared to the selling of insurance, although Medicare is not insurance, by a slick salesman who does not explain all of its provisions. When the purchaser signs up, and tries to use it, he finds too late that he has purchased an expensive piece of goods which does not begin to furnish that which he has been lead to believe

it would. I am convinced we will have to wage our campaign at the grass roots level. Nobody listens to the voice of Medicine at the national level nor at the state level anymore.

The American people, rightly or wrongly, have elected a majority of legislators who do not think as Medicine thinks. A good many of these people have been mislead by false promises. The social planners are tireless. They work at all levels constantly. If we are to influence the opinion of the American people, we must do it at the local level. Fortunately, even though the American people have a distrust of organized medicine at the national level and perhaps at the state level, most individuals still respect their own doctor. It is imperative that each doctor in each community embark on a program of speaking to service clubs, explaining what these government programs will cost, what they will do and more importantly, what they will not do. We can engage the help of allied professions such as pharmacy, dentistry, the insurance companies, and the like. We need not be orators. All we must do is be informed and present the facts to the American people at the local level. In this way perhaps we can educate enough people to elect legislators who share our convictions.

There are many positive approaches to our current problems. No one mind nor any small group of minds can come up with all the answers. We need the help of all Doctors of Medicine—the old and young, the practicing physicians and the medical educators, the physicians in research and those in government and industry. My plea is for continuing communication between those various groups. We have made a small start with our Town and Gown Symposiums. But this could probably be enlarged to produce a workshop which would encompass all of the various segments of medicine.

Finally, we all are aware of the fact that Medicine in this country is going to go through difficult days in the near future. We as doctors must dedicate ourselves to giving to the public the best medical care possible. To do this, we must have the help of all physicians in organized medicine. I especially urge all of the younger men to develop an interest in medical society affairs and make known your willingness to serve, to your officers and councilors. There is plenty of room for appointments to active committees. This work takes time, but if we want Medicine in the United States and in Wisconsin to continue, and even to excel, the high level it has been proud of in the past, we need help from all of you. If you don't remember anything else I've said today, please remember this.

I've rambled enough, but I would like to leave you with these thoughts. Medicine is a great profession. We have only one reason for existence and that is to take care of the health needs of the people. There are many divergent views on how this can best be accomplished, but by a cooperative effort I'm sure it can be done. To do it best will require the effort of not just a few, but all of us. There's a job to be done. Let's get at it.

UW SCIENTISTS CITE POSSIBLE CAUSE OF MENTAL RETARDATION

A new metabolic error which may cause mental retardation has been identified by scientists at the University of Wisconsin Medical Center. Dr. Theo Gerritsen and Dr. Harry A. Waisman, director of the Joseph P. Kennedy Jr. Laboratories for Research in Mental Retardation, described the disease at a recent meeting of the Federation of American Societies for Experimental Biology.

They called the disease Hypersarcosinemia because the amino acid sarcosine is present in the blood in large amounts. Doctors Gerritsen and Waisman have suggested that the metabolic disease is caused by the body's inability to break down sarcosine. The disease was discovered in a slightly retarded one-year-old child who excreted large amounts of sarcosine in his urine and had high sarcosine levels in his blood.

Further investigations showed that another child in the same family was also affected with Hypersarcosinemia. Doctor Waisman said that the affliction of two children in the same family indicates that this metabolic error is not accidental but hereditary.

The parents and four children were given tests to determine which enzymes were involved in the bodies of these children. Sarcosine excretion and blood level could be increased by oral loads of sarcosine and DMG, a precursor of sarcosine. In the two children not affected by the disease, no increased sarcosine excretion was found, said Doctor Waisman.

As yet, no cause for the retardation is known. Doctors Gerritsen and Waisman are not sure of the genetics of the parents of the affected children. Future investigation with the use of radioisotopes is expected to solve these problems, said Doctor Waisman.

This research is being supported by grants from the National Institutes of Health and the Joseph P. Kennedy Foundation.

Intestinal Ulceration Related to Medication

By ALBERT G. MARTIN, M.D., DAVID J. CARLSON, M.D. and ERWIN S. HUSTON, M.D., Milwaukee, Wisconsin.

■ WITHIN THE PAST few years, a new lesion of the small intestine has been recognized with increasing frequency. It presents as nonspecific ulceration and frequently manifests complications of perforation, hemorrhage, and stenosis.

Ulceration of the ileum has been uncommon until recently, only about 170 cases having been published prior to 1963.[1,2] Usually the diagnosis has been "primary, nonspecific ulcer." Most frequently, the lesion is a single ulcer, but multiple ulcers have been encountered. The ulcers we have seen were approximately 1.0 x 0.5 cm in size, with the long axis in line with the circumference of the intestine. Deep penetration into the muscular layers is the rule. While any part of the small intestine may be affected, the terminal ileum is the most common site.

Baker et al[3] encountered 12 patients with this lesion in a period of 15 months. The lesion, while small and nonspecific, can be lethal. Of the 12, two patients died, one postoperatively and one of peritonitis before an operation could be performed. The other 10 were operated upon and recovered. Several of these patients had received nonsurgical treatment for partial small intestinal obstruction prior to operation. Their study also shows that 11 of the 12 patients were receiving enteric-coated preparations containing hydrochlorothiazide and potassium chloride.

Morgenstern et al[4] have recently described 17 additional cases in which a relationship between ulcers of the ileum and thiazide-potassium drugs seemed probable.

Lawrason et al[5] quote experimental work on monkeys and dogs by Diener[6] and Bokelman.[7] Potassium chloride preparations given orally to monkeys produced ulceration of the stomach or intestine, depending upon the site of availability of the potassium chloride from the preparation administered. Tablets of diuretics in combination with potassium chloride, diuretics alone, potassium chloride alone, and a 5 per cent syrup of potassium chloride were used. The preparations containing potassium chloride in enteric-coated tablets usually produced intestinal ulcers. The other preparations containing potassium usually produced gastric ulcers. The locus and severity of the lesions in the monkey depended upon the dose, duration and whether the preparation was enteric coated. Preparations containing only the diuretic and enteric-coated sodium chloride tablets produced no lesions.

The purpose of this report is to describe clinical and pathological characteristics of this syndrome.

Case 1 (ileal ulcer, obstructive).—A 65-year-old white man was admitted to the hospital with a chief complaint of nausea and vomiting for four days. He had no pain. The abdomen was rounded and soft without tenderness or demonstrable mass. X-ray studies showed scattered gas shadows in small intestine and colon as well as moderate dilation of the small intestine.

Ten years previously this man underwent a right colectomy and resection of the terminal ileum for ileo-colic intussusception due to lymphosarcoma of the ileum. Numerous lymph nodes containing tumor were removed. The operation was followed by vigorous x-ray therapy which left the lower abdominal wall indurated and the skin over it telangiectatic.

Five years before admission progressive memory failure climaxed by a grand mal seizure prompted investigative measures which showed diffuse cortical atrophy. Diphenylhydantoin sodium (Dilantin), 100 mg three times daily, and phenobarbital, 15 mg four times a day, effectively controlled the seizures.

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Doctor Huston is Attending Physician, Milwaukee Hospital.

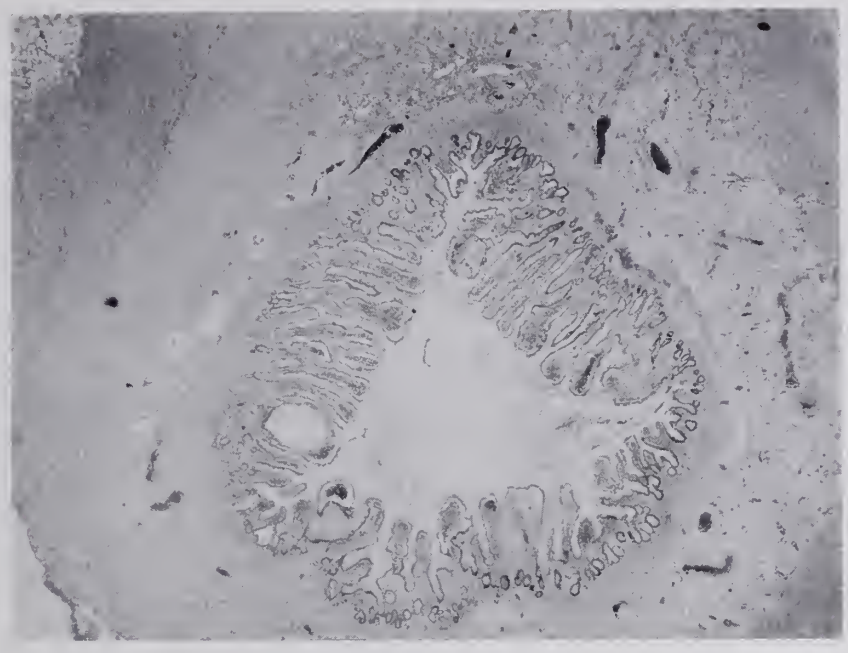

Fig. 1—Case 1. Ileum. Cross section showing narrowing of lumen and thickening of wall. x13.

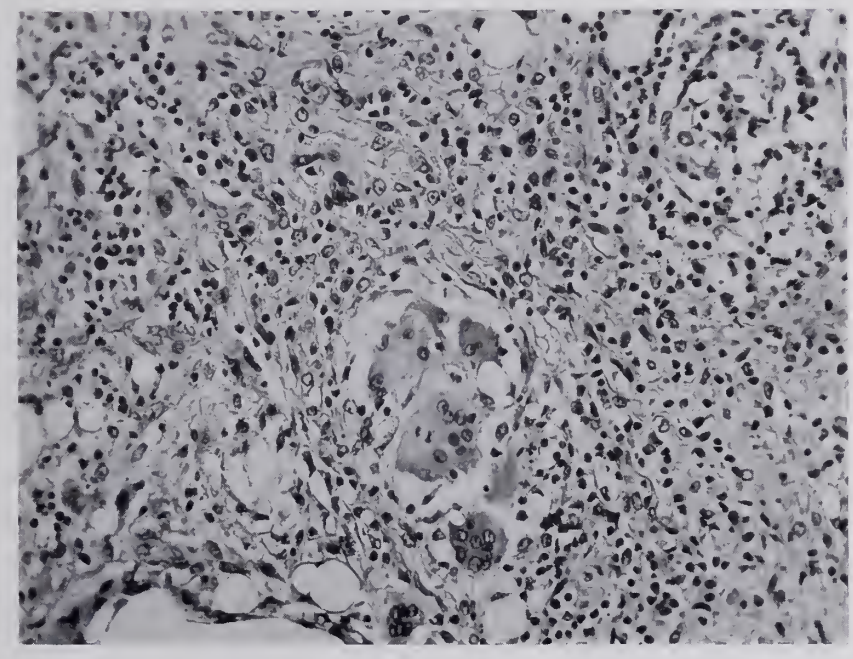

Fig. 2—Case 1. Mesentery. Focal fat necrosis, fibrosis, and lymphocytic infiltration. Note giant cells. x240

Four and one half years before admission bilateral ankle edema developed for which enteric-coated tablets containing 2.5 mg of bendroflumethiazide and 500 mg of potassium chloride (Naturetin with K) were prescribed. The tablets were taken twice daily and the treatment was effective. The patient's memory defect, however, represented

a handicap. The fact that he was still taking this preparation, possibly irregularly, was not discovered until after operation.

The preoperative diagnosis was intestinal obstruction, cause to be determined. Recurrence of lymphosarcoma, radiation injury to the ileum, and peritoneal adhesions were suspected.

At operation no evidence of lymphosarcoma was found. A mass consisting of matted ileum was adherent to the right side of the bladder. The center of the mass consisted of a loop of knuckled, sharply constricted ileum. On one side it was adherent to the bladder; on the other it was adherent to another loop of ileum. The intestine showed dilation proximally and collapse distally. All of the adhesions were fibrous, suggesting a chronic process. Adherent bladder and ileum were separated from the central ileal loop. The constricted portion of ileum was resected and an end-to-end anastomosis was made. The patient made a good recovery and left the hospital 12 days later.

The resected segment of ileum measured 6.0 cm in length. The serosa was covered by a thin layer of fibrinous exudate. At its mid portion there was hemorrhagic discoloration and puckering of serosa. The lumen at this point was narrowed and almost completely obliterated for a distance of 1.5 cm (Fig 1). The mesentery attached to this portion of bowel was indurated, edematous, and fibrous.

Microscopic examination of the narrowed segment showed marked edema of the mucosa with ulceration. There was increased vascularity with fibrosis within the submucosa. Inflammatory infiltrate, chiefly lymphocytes and plasma cells, was found in all layers. Beneath the ulcer the muscularis was replaced by proliferating fibroblasts accompanied by diffuse lymphocytic infiltration and hyperemia. The adjacent mesenteric fat showed focal necrosis, lymphocytic infiltration, and fibrosis (Fig 2). There was no evidence of radiation injury or lymphosarcoma.

Case 2 (ileal ulcer with gangrene and impending perforation).—A 59-year-old white woman was admitted to the hospital for elective cholecystectomy. Her complaint was bloating and indigestion after eating fat and fried foods. X-ray studies showed a solitary gallstone, a normal colon, and a normal stomach and duodenum. Because of hypertension she had been taking an enteric-coated tablet of hydrochlorothiazide, 50 mg, with potassium chloride, 1 gm (Esidrix-K) once daily for three months.

Six days before admission she developed colicky mid-abdominal pain. The pain followed eating solid food. It was relieved by a liquid diet. There was occasional reference of pain to the back.

The abdomen was rounded, obese, and soft. No scars were present. Poorly defined right upper quadrant and central lower mid-abdominal tenderness were elicited. There was no spasm or mass. Borborygmi were normal. Vaginal and rectal examinations were not remarkable.

Laboratory studies showed a hemoglobin level of 14.3 gm/100 ml, hematocrit reading 43%, white blood cell count 9,500/cu mm with 77 segmented neutrophils, 5 stab forms, 8 lymphocytes, 8 monocytes, and 2 eosinophils. Urinalysis, prothrombin time, serum bilirubin, and alkaline phosphatase were normal.

Because the x-ray studies of the gallbladder raised the question of a right renal stone, an intravenous pyelogram was done. It was normal.

The preoperative diagnosis was chronic calculus cholecystitis. In addition the possibility of intestinal disease was considered. For the latter reason laparotomy seemed preferable to more barium studies and was performed soon after admission.

The expected stone was present in the gallbladder which was thickened and distended but showed no acute inflammation. The other upper abdominal structures as well as the colon and pelvic organs showed no abnormality. In the area of the ileum where Meckel's diverticulum is usually found, a firm mass was present. Omentum had become adherent to the intestine for a distance of 4 to 5 cm. At one edge of the attached omentum gangrene of ileum was evident. The mesentery was not grossly affected. The involved ileum with the attached omentum was resected and continuity was restored by end-to-end anastomosis. The gallbladder was then removed.

The patient made an uncomplicated recovery and left the hospital on the ninth postoperative day. Cultures taken from the ileal lumen showed the usal flora.

The segment of ileum measured 6.5 cm in length. The serosa was hyperemic and finely granular. The attached omentum showed comparable hyperemia and induration. Opening the intestine disclosed an annular gan-

Fig. 3—Case 2. Margin of ulcer. Note heavy cellular infiltration of adjoining submucosa. x40.

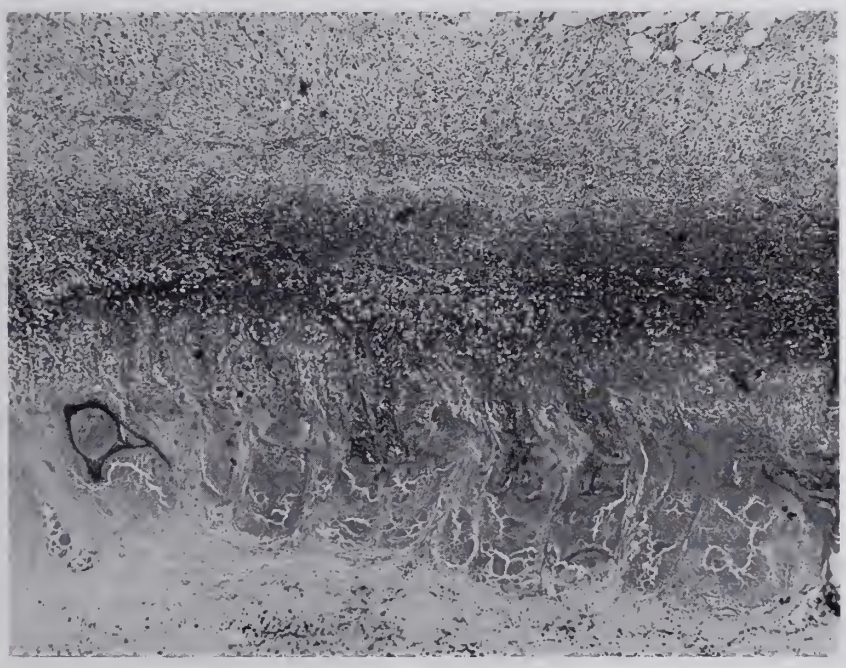

Fig. 4—Case 2. Wall of ileum showing complete necrosis of wall, ulceration, exudate on surface and mesenteric inflammation. x40.

grenous ulcer varying in width from 5 to 15 mm. The area was yellow green. Necrosis extended through the wall with a small 3 mm area of yellow green discoloration apparent on the serosal surface.

Microscopically the ulcer was covered with debris and purulent exudate (Fig 3). Necrosis of the entire wall was present with neutrophilic infiltrate and edema (Fig 4). The attached omentum showed edema, fat necro-

sis, fibroblastic proliferation and inflammatory cell infiltrate. The last included all varieties of inflammatory cells with predominance of lymphocytes. Eosinophils were also moderately numerous.

Case 1 Readmission (ileal ulcers with perforation, necrosis, and obstruction).—This patient was readmitted to the hospital three months after his recent discharge. He complained of severe diffuse abdominal pain of sudden onset, nausea, and vomiting. The abdomen was rounded, silent, and diffusely tense with right lower quadrant tenderness and spasm. The findings were interpreted as indicative of peritonitis. Nonoperative treatment was followed by prompt steady improvement for four days when signs of partial intestinal obstruction developed.

At laparotomy a subacute perforation sealed against the abdominal parietes required freeing and was closed. A loop of ileum had doubled upon itself thereby sealing another or possibly two subacute perforations. The loop had caused partial obstruction. In addition, a thin white circumferential patch measuring 1.0 x 0.5 cm was present in the ileum proximal to the obstructing loop. The patient's condition precluded resection. The proximal ulcer was excised. The obstructing loop was short circuited by side-to-side anastomosis. Although the operation was not as ideal as resection would have been, recovery from it was satisfactory. Recovery was complicated and delayed by recurrence of grand mal seizures and by renal insufficiency.

The nature of the lesion was recognized at this time. Inquiries of the family disclosed that the patient had been taking two or three of the diuretic-potassium tablets daily.

The ulcer removed was dark green to black, grossly necrotic, and slightly friable. Microscopic examination revealed necrosis of the entire wall most marked within the mucosa. Architectural outlines were obscured but recognizable.

Comment. Reports of intestinal lesions characterized by ulceration and usually involving the ileum have begun to appear with increasing frequency. The pathological process appears to be primarily necrotizing inflammation which involves all layers of the intestine, usually penetrating deeply into the muscular layers. The process is indolent with fibroblastic proliferation and granulation following closely upon the acute necrosis. This last apparently protects to some extent against acute perforation. It also allows for gradual thickening of the intestinal wall with contraction and eventual compromise and stenosis of the lumen. The mesenteric reactions apparently represent direct extension into the mesentery by the necrotizing inflammation.

It is understandable that presenting symptoms are usually those of intestinal obstruction, peritonitis, or even hemorrhage. Obstruction has been the most frequent complication, particularly in the form of partial obstruction. In the larger experience of others and in our limited experience perforation has often taken the form of a subacute process with sealing by adhesion to other intra-abdominal structures. Free perforation has, however, been reported. Severe hemorrhage has also been reported. This lesion should be included in the differential diagnosis of intestinal obstruction, the acute abdomen, and gastrointestinal hemorrhage.

At the time of operation, the early lesion has the form of a circumferential ulcer. The ulcer is discreet, gray, and surrounded for a short distance by thickened inflamed intestine. When the ulcers are multiple or confluent, the changes are correspondingly multiplied. The lesion gives the impression of producing a defect or deficit in the intestinal wall. When the acute ulcer has become adherent and must be separated, it then disintegrates and is represented by a circumferential hole of the same proportions. Acute perforations are reported as showing this appearance. In the further phase of obstruction the narrowed intestine again gives the impression of having lost substance, as indeed it has, at the point of narrowing. Unless it is covered and obscured by omentum, the lesion is quite unlike the familiar characteristics produced by postoperative peritoneal adhesions, Meckel's diverticulum, benign and malignant tumors, foreign bodies, and regional enteritis. As contrasted with typhoid involvement of the ileum, these lesions are more discreet. The treatment of choice is resection.

Middle-aged and elderly people are most frequently affected. Concurrent chronic cardiac, vascular, or renal disease, often in combination, may be present. Many affected patients have taken enteric-coated diuretic-potassium chloride preparations. At the present writing, enteric-coated potassium chloride is suspect as the causative agent. The

irritating characteristics of potassium chloride given intravenously and orally are well known, and have stimulated the development of the enteric-coated tablet. Such tablets have been found at the point of an ileal perforation. And yet only a small percentage of humans who take these medications develop intestinal ulcers. Ulcers such as these do occur in patients who have not taken potassium or diuretics and are also reported occasionally in the older literature. Cardiovascular disease has been postulated as a cofactor in the development of these ulcers and it may be. On the other hand, circumferential ileal ulcers have been reported in patients who had no demonstrable cardiovascular disease and were taking enteric-coated thiazide-potassium chloride preparations for weight reduction and premenstrual tension.

We have been alerted to this lesion in patients who have abdominal complaints, particularly middle-aged and elderly people. The diagnosis may be obscured by other concomitant illnesses. Moreover, the history of medication such as enteric-coated thiazide-potassium tablets may not be elicited during initial interviews. We have discontinued the use of enteric-coated potassium preparations.

324 East Wisconsin Avenue (53202).

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FDA Announces New Rules for Distribution of Coated Potassium Tablets

Coated potassium tablets, recently associated with small-bowel lesions, have been ruled New Drugs requiring submission of New Drug Applications, Commissioner George P. Larrick, Food and Drug Administration, U. S. Department of Health, Education, and Welfare, announced May 1.

Commissioner Larrick said the products will be placed on the prescription list and will be required to bear new warning information to physicians.

He also announced that uncoated potassium tablets and liquid potassium preparations are being placed on the prescription list and required to bear "full disclosure" labeling and certain instructions concerning dilution before use. Unlike the coated tablets, he said, the latter drugs will not require submission of New Drug Applications.

The announcements were in a Statement of Policy published in the Federal Register April 24, 1965. Manufacturers had 30 days from this date in which to comply with the Policy Statement regarding labeling including the prescription requirement. They have 90 days from this date in which to submit to FDA New Drug Applications for coated potassium tablets.

FDA Medical Director Joseph F. Sadusk, M.D., said the actions regarding coated potassium tablets are based on new evidence of clinical experience which shows an association with non-specific small-bowel lesions, sometimes with ulceration. Doctor Sadusk said that these small bowel lesions have caused obstruction, hemorrhage and perforation, have necessitated surgery and have resulted in some deaths.

FDA said that coated potassium salt tablets or any capsule of potassium salt supplying 100 milligrams or more of potassium intended for oral ingestion without prior dilution with liquid must, within 30 days from the Federal Register publication, bear the prescription legend and the following warning statement:

"Warning—There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required and deaths have occurred. Based on a large survey of physicians and hospitals, both United States and foreign, the incidence of these lesions is low, and a causal relationship in man has not been definitely established. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practicable."

FDA said that uncoated potassium tablets and liquid preparations which supply 100 milligrams or more of potassium per tablet or teaspoonful must, within 30 days from Federal Register publication, bear the prescription legend. They must also conform with the "full disclosure" labeling requirements including a recommendation that patients be directed to dissolve any such tablets in an appropriate amount of liquid and to adequately dilute the liquid preparations to prevent gastrointestinal injury.

Frequency of Snakebites in Wisconsin

By HENRY M. PARRISH, M.D., Dr. P.H.
Columbia, Missouri

■ POISONOUS SNAKEBITES do not occur frequently in Wisconsin. However, they do occur rather frequently in some of the other member states of the East North Central Region of the United States. The annual snakebite rates per 100,000 population for states in this region were: Indiana (0.97), Michigan (0.74), Ohio (0.46), Wisconsin (0.38), and Illinois (0.35). Very little is known about poisonous snakebites in Wisconsin. There has never been a systematic study of this problem in the state before. However, deaths from snakebites are rare in Wisconsin. During the 10-year period, 1950–1959, there were no snakebite deaths in the state.[1]

Poisonous Snakes. According to Klauber,[2] the following two species of poisonous snakes are indigenous to Wisconsin: the timber rattlesnake *(Crotalus horridus horridus)* and the eastern massasauga *(Sistrurus catenatus catenatus)* (Fig 1). Massasaugas are small rattlesnakes. They are confined to the southern and southwestern parts of Wisconsin. Timber rattlers are found in the southwestern part of the state. Cottonmouth moccasins, copperheads, and coral snakes are not native to Wisconsin.

All of Wisconsin's poisonous snakes are pit vipers. They are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Harmless snakes do not have facial pits. They have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Oftentimes people will chop off the head of a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by turning the snake's belly upwards and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates. Figure 2 depicts the characteristic features of pit vipers and harmless snakes.

Methods of Study. A questionnaire and letter explaining the purpose of this study were mailed to a "selected" group of Wisconsin hospitals listed in HOSPITALS (Journal of the American Hospital Association) Guide Issue. The hospitals selected for this study were general hospitals, children's hospitals, and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force, and

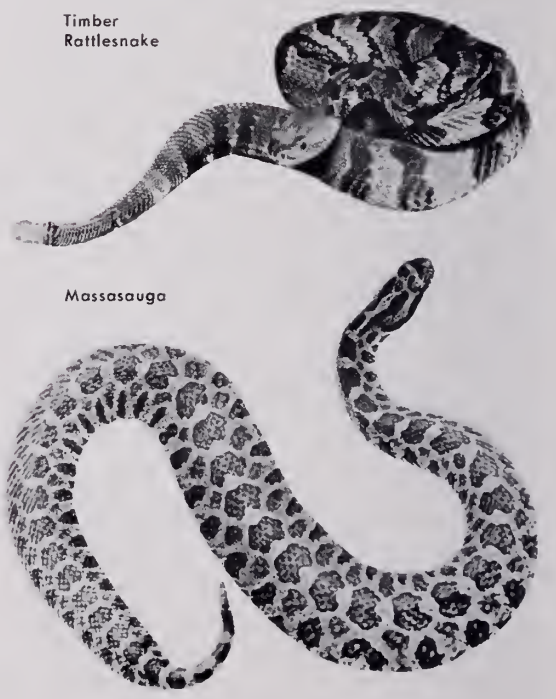

Fig. 1—Paisanous snakes indigenous to Wisconsin.

From the Department of Community Health and Medical Practice, School of Medicine, University of Missouri.

This investigation was supported in part by Public Health Service Research Grant GM 11268–02 from the Division of General Medical Sciences, Public Health Service.

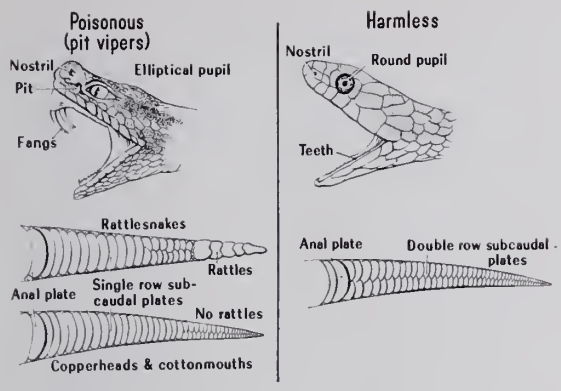

Fig. 2—Characteristic features of poisonous (pit vipers) and harmless snakes.

Veterans Administration hospitals were also sent questionnaires. Maternity, tuberculosis, and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 152 Wisconsin hospitals comprised the study group. Each hospital was requested to report all inpatients admitted to the hospital for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and outpatient clinic visits. Since some snakebite victims are not admitted to the hospital as inpatients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an outpatient (office, home, emergency room, and the like) and on an inpatient basis. Previous surveys,[3, 4] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. Therefore, a random sample of one-third of all the Wisconsin physicians in these categories of practice who were listed in the A. M. A. AMERICAN MEDICAL DIRECTORY were sent questionnaires.

Death certificates for fatal snakebite cases were requested from the Wisconsin State Board of Health.

Results. This report is based on questionnaires returned by 100 per cent of 152 Wisconsin hospitals. It is supplemented by questionnaires returned by 603 (81%) of 747 practicing physicians in the state. The Wisconsin State Board of Health indicated that there were no snakebite deaths during 1958 and 1959.

INCIDENCE. Wisconsin hospitals reported a total of 6 inpatients treated for poisonous snakebites during 1958 and 1959. There were 3 cases in 1958 and 3 cases in 1959. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 6 detailed case reports received from hospitals.*

Physicians' reports, when adjusted to account for all Wisconsin physicians in the practice categories mentioned, indicated that approximately 7 inpatients and 8 outpatients were treated for snakebite accidents each year. Many physicians stated that they had never treated a poisonous snakebite. The difference between the estimate of 7 inpatients treated by physicians and the average of 3 inpatients reported by hospitals can be explained by the fact that there was evidence of under reporting snakebite inpatients from five hospitals which participated in the study. Taking all of these various reports into consideration, I estimate that approximately 15 (7 inpatients and 8 outpatients) people are treated annually for poisonous snakebites in Wisconsin. This provides an incidence of 0.38 bites per 100,000 population per year.

GEOPATHOLOGY. The geographical distribution of snakebites reported in Wisconsin during 1958 and 1959 may be seen in Figure 3. The lightly shaded counties are those from

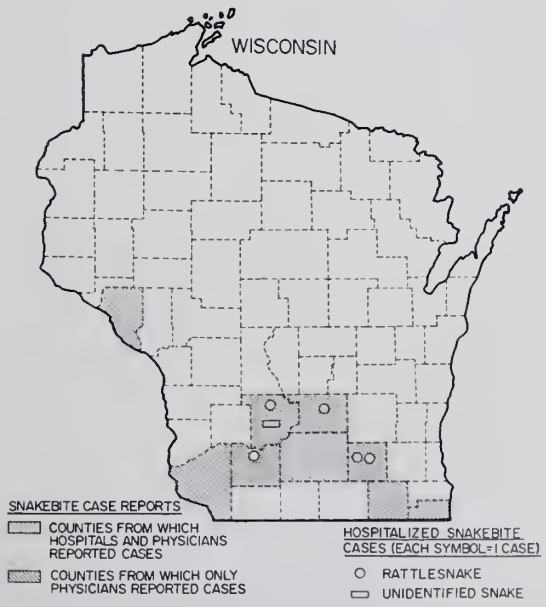

Fig. 3—Geographical distribution of poisonous snakebites in Wisconsin, 1958 and 1959.

which hospitals reported inpatients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 6 people hospitalized for snakebite treatment for whom detailed records were available, 5 (83%) were bitten by rattlesnakes and 1 (17%) by an unidentified poisonous snake. Most likely the bite attributed to an unidentified poisonous snake actually was inflicted by a rattlesnake.

Figure 3 shows that with one exception all of the snakebites occurred in the southern one-third of Wisconsin. The remaining bite was reported from west central Wisconsin. The geographical patterns of bites by various kinds of poisonous snakes in Figure 3 are consistent with the ecological ranges of poisonous snakes in Wisconsin described by Klauber.[2]

TEMPORAL RELATIONSHIPS. Snakebites were infrequent during the colder months of the year—September through April. In general, snakes are usually inactive and/or hibernating during the colder months. Of the six snakebites, one occurred in May, two in June, two in July, and one in August. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England and North Carolina.[3, 4]

The time of day when most snakebite accidents happened was the three-hour period from 12 noon to 2:59 p.m. when three people were bitten. The number of bites by three-hour periods of time were: 9 to 11:59 a.m., one bite; 12 noon to 2:59 p.m., three bites; 3 to 5:59 p.m., one bite; and 6 to 8:59 p.m., one bite. There were no bites from 9 p.m. through 8:59 a.m.

BITE VICTIMS. There were five white males, one white female, no nonwhite males, and no nonwhite females admitted to Wisconsin hospitals for snakebite treatment during 1958 and 1959. In most states males have higher bite rates than females and whites have higher rates than nonwhites.

The age distribution of Wisconsin bite victims was as follows: 0–9 years of age (1 bite); 10–19 years (2 bites); 40–49 years (2 bites), and 60–69 years (1 bite). Fifty per cent of all snakebites were inflicted on children and young adults less than 20 years of age.

An analysis of the occupations of the patients showed that three were children, and one each was a professional snake handler, a farm laborer, and a laborer other than a farm laborer.

The bites occurred while people were engaged in various activities. Three people were bitten while handling a poisonous snake, one person each was bitten while walking near a lake, while working on a farm not near the house, and while playing in a field near the house.

EDITOR'S NOTE: *The August 1964 issue of the* WISCONSIN MEDICAL JOURNAL *contained an article entitled, "Treatment of Poisonous Snakebites" by Howard Hyde, M.D. The treatment of pit viper bites advocated by Doctor Hyde is not in complete agreement with that suggested in this article. Doctor Hyde recommended that tourniquets be abandoned and that incision and suction of the bitten area was only useful as a first aid procedure and probably not helpful by the time the patient was seen by a physician. Readers are referred to Doctor Hyde's paper.*

SITE AND SEVERITY. All of the snakebites were inflicted on the extremities—three (50%) on the upper extremities and three (50%) on the lower extremities. The bites on the upper extremities were on the fingers and hands, whereas all bites on the lower extremities were on the lower legs including the ankles.

A modification of the clinical classification of pit viper venenation by Wood, Hoback and Green[5] was used to determine the severity of bites. Bites were classified as follows:

Grade 0—*No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema and erythema. No systemic involvement.

Grade I—*Minimal venenation.* Fang or tooth marks, severe pain, 1 to 5 inches of surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually present.

Grade II—*Moderate venenation.* Fang or tooth marks, severe pain, 6 to 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic in-

volvement may be present—nausea, vomiting, giddiness, shock or neurotoxic symptoms.

Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for six hospitalized cases: two (33%) were Grade 0; two (33%) were Grade I; one (17%) was Grade II; and one (17%) was Grade III. There were no fatalities among the six hospitalized cases in this series. Moreover, there were no fatalities among the estimated 15 poisonous snakebites that occurred annually during 1958 and 1959 in Wisconsin. The case-fatality rate for snakebites in Wisconsin is estimated to be less than one-half of one per cent. This is confirmed by the fact that there were no snakebite deaths in Wisconsin during the 10-year period, 1950 through 1959.[1]

Treatment. The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin, and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation,* and it should be released every 10 to 15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I.S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3 to 5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to I.S., in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given. For Grade I venenations antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000 ml of normal saline may be given intravenously.[6] Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.[7] Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various grades of venenation: Grade O (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10 ml (one ampoule) of antivenin; Grade II (moderate venenation) requires 30 to 40 ml of antivenin; and Grade III (severe venenation) requires 50 ml or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram-negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of

animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution, and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride.[7] In our opinion, cold therapy should not be used in treating pit viper bites.

Summary. Poisonous snakebites do not occur frequently in Wisconsin. An estimated 15 people are bitten annually, which provides an incidence of 0.38 bites per 100,000 people. The case-fatality rate is estimated to be less than one-half of one per cent.

Most of the reported bites occurred in southern Wisconsin from May through August. Of six bites reported in detail, five (83%) were inflicted by rattlesnakes and one (17%) by an unidentified poisonous snake. All of the bites were on the extremities.

The treatment recommended included incision and suction (I.S.) and "the 3 A's" (antivenin, antibiotics, and antitetanus prophylaxis).

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CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: D. J. CARLSON, M.D.
Milwaukee, Wisconsin

Case Presentation.*

A 57-year-old, single, white woman, employed as a bookkeeper, entered the hospital Sept. 15, 1964. She complained of increased facial hair, back pain, and a 12-pound weight loss over the previous two months. In addition, she had noted dysphagia and masses in the submental and right supraclavicular areas. The back pain was midthoracic and most severe on exertion. There was no history of fever, anorexia, dyspnea, cough, polyuria, edema, or change in bowel habits.

Past medical history included mild hypertension, treated with chlorothiazide (Diuril) and hypothyroidism treated with United States Pharmacopeia (USP) thyroid, 50 mg daily. Chlorothiazide therapy was discontinued when the patient developed nonthrombopenic purpura and dermatitis. There was also a history of frequent urinary tract infections.

She presented as a well developed, well nourished, white woman, appearing her stated age. Blood pressure was 200/110 mm Hg, pulse rate 105, and temperature 98 F. Examination of the head and ears, eyes, nose, and throat revealed fullness of the cheeks, with hirsutism of the upper lip. There was a 4-x-6-cm submental mass. The thyroid was smooth, firm, and enlarged. Supraclavicular nodes were palpable on the right. The areolae were darkly pigmented. Over the left scapula there was a subcutaneous mass measuring approximately 2 x 2 cm. Examination of the heart and lungs was not remarkable. There were silver striae over both flanks and the spleen tip was palpated by some examiners. The external genitalia showed no clitoral enlargement, and pelvic examination was normal. The extremities were negative, as was the neurological examination.

On admission the hemoglobin level was 16.2 gm/100 ml, hematocrit reading 52%, white blood cell count (WBC) 9,300/cu mm, with 90 segmented neutrophils, 2 stab forms, 4 lymphocytes, and 4 monocytes. Urine was free of sugar, albumin, and cells. Specific gravity was 1.009. Total serum proteins were 6.05, with albumin 2.9 gm/100 ml. Direct Coombs test was negative. Postprandial blood sugar was 170 mg/100 ml, and the glucose tolerance test showed a diabetic curve.

Blood urea nitrogen (BUN) was 17 mg/100 ml; serology was nonreactive. Intermediate purified protein derivative test for tuberculosis (PPD) was negative. Alkaline phosphatase was 10 King-Armstrong units, serum glutamic oxaloacetic transaminase (SGOT) was 29 units. Total bilirubin was 0.2 mg/100 ml, and the cephalin flocculation test was normal. Serum potassium was 2.7, sodium 144, chloride 96, and carbon dioxide 36.5 mEq. Initial urinary steroids were 17-ketosteroids, 17.1 (normal 5–15); 17-hydroxycorticosteroids, 56.6 (normal 2–10); and Porter–Silber chromagens, 32.8 mg/24 hrs (normal 4.0–8.0). Following suppression with 0.5 mg of dexamethasone every six hours, the steroids were 17-ketosteroids, 35.8; 17-hydroxycorticosteroids, 102.6; and Porter–Silber, 43.2 mg. With 2.0 mg of dexamethasone every six hours, the results were: 17-ketosteroids, 47.5; 17-hydroxycorticosteroids, 115.6; and Porter–Silber, 48.3 mg.

Electrocardiographic studies showed depression of ST segments in leads I, II, and V4 through V6; there were prominent U waves in leads II and III. The chest film on admission revealed lobulated densities about the right hilus. The sinuses and mandible were normal on x-ray. There was evidence of osteoporosis of the dorsal spine. On intravenous pyelography, poor filling of the left upper pole calices was noted. Nephrotomograms showed intrinsically normal kidneys, but also revealed a large mass above the left kidney. Barium enema was normal; upper gastrointestinal series showed esophageal compression in the midmediastinal area.

* From Milwaukee Hospital.

On Sept. 21, 1964, an operation was performed. Following surgery the patient received cobalt therapy and was placed on medication which resulted in normal urinary steroid levels by November 30. Her course was ingravescent. She developed fever, hemoptysis, and pulmonary infiltrates which responded to penicillin and streptomycin therapy. In addition, there was a drop in the hemoglobin level to 7.8 gm. Iliac crest bone marrow examination showed a hypocellular marrow, with a 1:1 M–E ratio. The red blood cell half-life was 15 days (normal 25–35 days). The patient received 3 units of whole blood prior to discharge on December 5. She died at home on December 25.

Clinical Discussion. *Dr. Edward Lennon:** This is an interesting problem of a 57-year old woman whose illness dated to about two months before admission to this hospital. She died 14 weeks later. She rapidly revealed herself by history, physical examination, and laboratory tests to have Cushing's syndrome. My task, then, is to attempt to discover the etiology.

It is difficult for me to date the exact onset of her illness. We are told that she had hypertension in the past. I'm not certain when this was originally discovered.

Dr. Neil Barber: Approximately five years ago.

Doctor Lennon: In view of what develops later, I think that the history of earlier hypertension is probably a "red herring" and was due to some other cause during this interval of time.

The second thing that occurred in the past is nonthrombocytopenic purpura while being treated for hypertension. This was justifiably attributed to chlorothiazide therapy, since she also had an associated skin rash. Were this not the case, one might have wondered whether the purpura was related to Cushing's syndrome. At the time of admission to the hospital, those features pertinent to Cushing's syndrome included back pain, with radiologic evidence of osteoporosis, and some "fuzz" on her chin, which had increased in recent years. I would presume that she was weak, although this wasn't specifically mentioned. Did she complain of weakness?

* Director of the Clinical Research Center, Milwaukee County Hospital.

Dr. J. K. Olinger: Yes, she did.

Doctor Lennon: She also had facial fullness, areolar hyperpigmentation, and abdominal striae. The latter were nonspecific because they were silver and not the classic purple depressed striae of Cushing's syndrome. Hematologically, she showed moderate polycythemia, with a hematocrit reading of 52% and a striking lymphopenia. The total WBC was 9,300/cu mm, with only 4 lymphocytes. Lymphopenia is common in Cushing's syndrome, and a very helpful finding in this case.

At this point we must consider briefly the differential diagnosis of Cushing's syndrome. Cushing described this syndrome in 1932.[1] At the time, he thought that the development of the syndrome was due to the presence of a basophilic adenoma in the pituitary. Indeed, in some cases, small basophil adenomas have been found. It is common to find hyalinization (so-called Crooke's changes) of basophil cells. As years went along, however, this concept became increasingly discredited. The majority of patients with Cushing's syndrome did not appear to have primary pituitary disease.

When I was in medical school it was generally accepted that Cushing's syndrome was a primary disease of the adrenal gland. In 1960, Nelson and his coworkers described several cases in which bilateral adrenal resections had been done for Cushing's syndrome with subsequent development of intense pigmentation and enlargement of the pituitary, with erosion of the sella turcica. Chromophobe adenomas of the pituitary were found. Salassa[2] at the Mayo Clinic reported similar cases. Since that time, many of us recalled patients who had been adrenalectomized only to later develop pigmentation of skin and enlargement of the pituitary.

The usual Cushing's syndrome is not obviously due to a pituitary disorder until some time after the adrenals are removed and ACTH production becomes very high. The usual diurnal rhythm of ACTH (a rise in the morning hours and a fall as the day goes along) is abolished and continuous ACTH release occurs. The pathologic physiology of Cushing's syndrome associated with bilateral adrenal hyperplasia is apparently due to continuous production of cortisone throughout the day and night. In this situation, the adrenals are usually not greatly enlarged, seldom weighing more than 30 gm,

and total steroid production is not greatly increased, certainly not to the levels seen in this patient. These two kinds of disorder may then occur—Cushing's syndrome due to excessive pituitary production of ACTH and Cushing's syndrome due to autonomously overactive adrenals, due either to adenoma or carcinoma of the adrenal glands.

Interestingly, the third category was described prior to Cushing's publication. In 1928 Brown[3] of Great Britain described a patient who had oat-cell carcinoma of the lung, and symptomatology and clinical findings clearly identifiable in retrospect as Cushing's syndrome. Since then, there have been 40 or 50 cases reported of Cushing's syndrome associated with carcinoma of nonendocrine tissues. I don't really like to use the term "nonendocrine carcinoma." These malignancies arise in organs which do not normally produce endocrine secretion. In recent years the production of a variety of hormones by tissues (carcinomas in particular) which do not normally have endocrine function has been recognized. These include insulin, antidiuretic hormones, parathormone, gastrin, and other hormones.

I should point out that in the majority of patients who have had "nonendocrine carcinomas" producing ACTH, the tumors were oat-cell carcinomas of the lung. Indeed, the vast majority of these have been small round cell neoplastic lesions occurring somewhere in the mediastinum. They all tend to look very much alike. Some of them have been considered primary thymic tumors; others have been tracheal adenomas, bronchial adenomas, bronchogenic carcinomas, or oat-cell carcinomas. There have also been cases reported with carcinoma of the thyroid, gallbladder, intestine, testis, ovary (arrhenoblastoma), and others.[4]

Several groups[5,6] have demonstrated high levels of circulating ACTH-like activity (so-called "tumor ACTH") in the blood of such individuals. Moreover, the tumor may contain large quantities of an ACTH-like material. This ACTH is very similar to pituitary ACTH by all tests available. The pituitary in such cases contains very little ACTH.

This, then, appears to be an aberrant source of ACTH production. It differs considerably in the effects that it produces on the adrenals as compared to the usual instances of Cushing's syndrome. The adrenals tend to be very much larger. Asymmetric adrenal enlargement is common. Larger quantities of adrenal steroids are found, certainly more than the amount found in simple bilateral adrenal hyperplasia.

There are some odd features which direct my attention away from a "run of the mill" Cushing's syndrome. In the first place, this lady had weight loss in contrast to the expected modest increase in weight. She had dysphagia, which was later found due to mediastinal involvement by nodular densities compressing the esophagus. Submental and supraclavicular masses were found, and she had an enlarged, smooth, nontender thyroid gland. In addition to this, she had a mass over her scapula. All of these findings suggest wandering neoplastic cells.

She also had hypokalemic alkalosis. In general, patients with Cushing's syndrome due to bilateral hyperplasia do not have hypokalemia. This occurs in only some 15 to 20 per cent of cases. It is more common in patients with adrenal carcinoma or adrenal hyperplasia due to "tumor ACTH."[7] Thus, alkalosis and hypokalemia make me suspicious. She is said to have had splenomegaly. In retrospect, however, I think that the examiners were feeling her left kidney, which is said to have been pushed down by an adrenal mass. An adrenal mass large enough to be seen on x-ray films suggests again that we are not dealing with simple bilateral hyperplasia. I cannot distinguish with certainty whether this enlargement was due to hyperplasia because of production of "tumor ACTH" or primary carcinoma of the adrenal gland. Perhaps x-ray evidence of size of the tumor will help us.

The urinary steroid levels were quite high. Three types of steroids were measured. The 17-ketosteroids, on initial determination, were slightly above normal. I would say, in passing, that this lady had no definite signs of virilization. The only convincing sign in the female is hypertrophy of the clitoris. She had no temporal recession of her hairline. The second value reported in the protocol is said to be "17-hydroxycorticosteroids." I suspect that this was really "17–ketogenic steroids." The ketogenic steroids measure three groups, all distinguished by substitution on the 17 carbon of the "D" ring. These include the dihydroxyketone group characteristic of cortisone and hydrocortisone, the glycerol group characteristic of cortol and cortolone (end products of cortisone and hydroxycortisone degradation) and the glycol group characteristic of preg-

Fig. 1—Nephrotomogram. Note triangular mass in left suprarenal area.

nanetriol. The Porter–Silber chromagens measure principally cortisone and hydroxycortisone.

How might the diagnosis be firmed up on physiologic grounds? First, the ease of suppression of adrenal steroid production was tested. She was given 2 mg of dexamethasone a day for a period of several days, and urinary steroids were measured. If anything, you will note that all increased. Normal individuals usually show decreased adrenal steroid production with 2 mg of dexamethasone a day. The dose was then raised to 8 mg and again, rather than a fall, a rise in the urinary steroid level was found. Eight mg of dexamethasone will usually suppress adrenal steroid production in simple bilateral hyperplasia of the adrenals. Again, the findings suggest adenoma, adenocarcinoma, or "tumor ACTH" as the cause of Cushing's syndrome in this case. One other thing that might have been helpful is an 8-hour IV infusion of ACTH. In distinguishing between adenoma or adrenal carcinoma as opposed to hyperplasia due to tumor ACTH, only 10 per cent of patients with adrenal adenocarcinoma or adenoma show any increase in steroid production after infusion of ACTH. Indeed, that 10 per cent may simply represent vagaries of secretion by autonomous adrenals. On the other hand, patients who have bilateral adrenal hypertrophy due to "tumor ACTH" are usually sensitive to infusion of pituitary ACTH. An increase in steroid excretion is expected.

I also would like to think for a moment about the patient's thyroid. It is stated that she was diagnosed as having hypothyroidism at some time in the past. Do you know on what basis this diagnosis was made?

Doctor Olinger: A protein-bound iodine (PBI) done in 1962 was less than 3 mcgm. That is the only thyroid function study we have on her.

Doctor Lennon: On clinical grounds, then, plus a low PBI, it was suspected that she was hypothyroid. Did she have a goiter at that time?

Doctor Olinger: Yes.

Doctor Lennon: She did. At clinicopathologic conferences one has to cover all of one's tracks. There have been several cases of Cushing's syndrome associated with carcinoma of the thyroid. The description of this lady's thyroid gland did not suggest this.

I would like at this point to ask Radiology if they would show me where these "lumps and bumps" were. Perhaps they or Pathology would tell me if these are compatible with metastases of adrenal cortical carcinoma, or whether they might be related to carcinoma elsewhere.

Dr. J. E. Garman: The excretory urogram showed the upper pole of the left kidney to be rotated laterally by a suprarenal mass. The left kidney and its drainage system appeared to be intrinsically normal. The right kidney appeared to be slightly lower in position than usual, but a suprarenal mass was not identifiable. Nephrotomography demonstrated the left suprarenal mass to advantage (Fig 1). The normal adrenal is triangular in shape and has concave borders. This mass maintained a triangular configuration, but its margins were rounded and convex. No calcification was identifiable within the mass, and it appeared to be separate from the superior pole of the left kidney which remained well defined. The right suprarenal area was well demonstrated and appeared clear without demonstration of a mass or the normal adrenal. The chest radiograph showed a lobulated density of the right hilum and bilateral lobulated superior mediastinal masses (Fig 2). There was a minimal infiltrate in the right lower lobe, which had an appearance consistent with atelectasis without major decrease in volume of the right lower lobe. A lateral film of the barium-filled esophagus showed the nodal mass at the tracheal bifurcation to indent the esophagus and displace it posteriorly.

Fig. 2—Chest. Note mass at inferior aspect of right hilus and lobulated right inferior mediastinal mass.

Doctor Lennon: I am inclined to put some weight on the downward displacement of the right kidney. There was no evidence of metastases to bone?

Doctor Garman: No. We had multiple films with which to examine bones of the thorax, spine, and pelvis, and no destructive lesions were found.

Doctor Lennon: An alkaline phosphatase of 10 units in your laboratory is acceptable as the upper limits of normal?

Dr. D. J. Carlson: Yes.

Doctor Lennon: I can only say that statistically, adrenal carcinomas tend to go both to liver and bone, as well as to lung. We have no evidence of bone or liver metastases. We do have an infiltrative process in lung, centered in the mediastinum.

A CPC is interesting only if the discussant goes out on a limb, and I'll be there shortly. I speculate that the patient had a left adrenalectomy. I would guess that a hyperplastic, somewhat nodular, gland was found that may have contained metastatic tumor, but was not itself a carcinoma. She was then treated with cobalt therapy, which I presume was to her chest and neck. Then the cryptic statement is made that she was given a "drug," nature unspecified, which by November 30 caused her urinary steroid excretion to drop to normal. Three drugs come to mind, and I cannot decide which of these might have been chosen. The first agent is amphenone-B, described in 1955.[8] Amphenone-B was found to inhibit adrenal steroid production, and to cause accumulation of lipid in the adrenal gland. It was used in the treatment of some patients with adrenal carcinoma, but was not a smashing success. Then, a few years later in the insecticide industry, it was discovered that a derivative of chlorophenothane (DDT), called tetrachlorodiphenylethane (DDD), was able to produce necrosis of the adrenal in the dog. It was later found that the antiadrenal action was due to an impurity designated as o-p'DDD.[9] This drug has been used with some success in treating adrenal carcinoma. The antiadrenal action of the last drug was discovered accidentally when triparanol was marketed for the reduction of serum cholesterol. Mild adrenal insufficiency was found if the drug was used in larger than normal doses (1000 mg a day significantly inhibiting the synthesis of adrenal steroids). The "medicine," then, could have been any one of these agents. My guess is that it was o-p' DDD because it has been, in general, the most successful.

Her course thereafter was characterized by new pulmonary infiltrates. I have no idea what these were. They might have been due to emboli, to pneumonitis, or to metastases. She apparently responded to penicillin and streptomycin therapy, suggesting infection. However, her hemoglobin level dropped. She was shown to have a hypocellular marrow and decreased red blood cell half-life. This is compatible with what may occur in carcinomatosis.

To step out to the last leaf of the limb—I am inclined to say (because it is the more interesting diagnosis) that this lady's primary problem is going to turn out to be in the mediastinum. She probably had a small round cell tumor, which might have begun in tracheal node, thymus, bronchus, or almost anywhere in this area. This invaded thyroid, submandibular gland, and skin. Moreover, this tumor produced ACTH. For this reason, I would expect her to have bilateral adrenal hyperplasia, asymmetric, with the larger gland on the left.

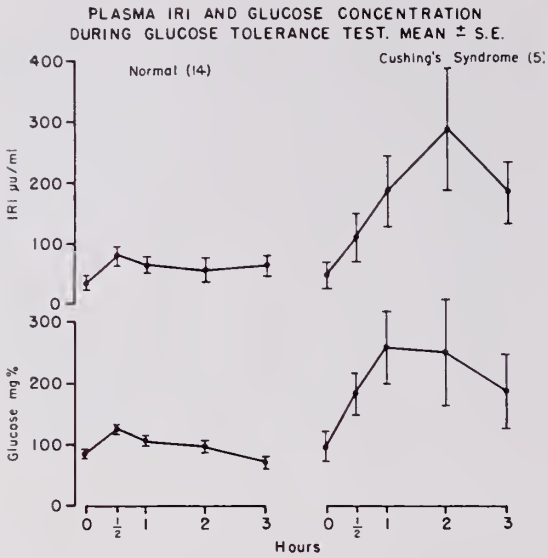

Figure 3

Doctor Olinger: When one has a problem of this sort, it is gratifying to see wide interest shown by one's professional colleagues. We found that among our staff members we were able to collect a great amount of information that was helpful in the diagnosis and management of the case. I think that it is only fair to add that the operation performed was not adrenalectomy, but removal of right supraclavicular mass. The histology of this node was described as an epithelial cell carcinoma. Breast was suggested as a possible primary site. We found nothing on examination to suggest primary malignancy in the breast. I carried this information back to the Laboratory, and was informed that the epithelial cellular appearance of the tumor was, in fact, compatible with primary neoplasm in almost any organ. I wonder if this information changes Doctor Lennon's diagnostic considerations in any way?

Doctor Lennon: Doctor Olinger, there have been a number of cases of this sort associated with carcinoma of the breast. These again tend to be small round cell tumors. Moreover, in a number of instances, clinically apparent carcinoma of the breast appeared some time after Cushing's syndrome was obvious. Primary breast carcinoma is certainly not excluded, but when pathologists describe cell morphology, I'm usually better off sticking to what I thought on overall clinical grounds.

Dr. D. D. Klink: The carbohydrate intolerance this patient experienced was studied in association with serum insulin levels at the Milwaukee Veterans Hospital. The first glucose tolerance test revealed a fasting level of 100, one hour 225, two hours 230, and three hours 236 mg/100 ml. I believe all would accept this as being clearly abnormal. Glycosuria occurred at two and three hours. Insulin levels were performed on serum samples drawn during the glucose tolerance test. These revealed—fasting, one-hour, two-hour, and three-hour values of less than 5, 41, 64, and 58 microunits per milliliter respectively. The late peak at two hours is typical of insulin response in adult onset diabetes, but the absolute levels are considerably less than anticipated. The explanation for this is not clear.

I did not make a separate graph of this patient's data, but Figure 3 explains some work at the Cincinnati General Hospital in 5 patients with Cushing's syndrome. One case was iatrogenically induced, one adrenal carcinoma, one hyperpituitarism, and two with adrenal hyperplasia. In the top left-hand corner are the immunoreacting insulin levels in 14 normal patients. There is very minimal elevation, with a peak at about half an hour. In the left lower corner are the absolute glucose levels in these cases. There was a rise at one-half hour, with subsequent fall to the fasting level.

As opposed to this, it was our experience in 5 cases of Cushing's syndrome to find quite a different picture. Note in the right lower corner that these people demonstrated glucose intolerance very similar to that seen in this case. At the same time, in the upper right-hand corner you see a graph of the plasma insulin levels performed with the immunoassay procedure of Goetz. Despite normal fasting values, there was a delayed rise to quite high levels at two hours. I think this is typical of what has been found in hyperadrenocortical states. There is carbohydrate intolerance. The insulin output does occur, but in a fashion very similar to that in adult stable diabetic patients. The rise is delayed and to much higher levels than normal.

The carbohydrate intolerance seen with elevated levels of adrenocortical steroids is usually asymptomatic and rarely requires treatment. In a few people, iatrogenically induced hypercortisonism leads to frank dia-

betic acidosis. I've seen this develop in one 17-year-old girl after one month's treatment with prednisone for rheumatic carditis. This, however, is rare.

In this case I believe there are many aspects, as have been pointed out by Doctor Lennon, which support malignancy. I would like to reemphasize first that in most cases of ACTH-producing tumors the clinical picture is as seen here. There is marked chemical evidence of adrenocortical overactivity, but the associated clinical picture is often less striking than in adrenal hyperplasia. Most people believe that this is related to the short time during which these patients are exposed to elevated steroid levels. In addition, I would like to refer to hypokalemic alkalosis. It is typically more severe and more frequent in Cushing's syndrome associated with malignancy. There has been some speculation, but no definite proof of its cause. Hyperaldosteronism has been incriminated by some. However, to my knowledge, there has been only one case in which such was supported, and that was a case of Cushing's syndrome associated with prostatic carcinoma. Currently most investigators seem to believe that the much greater glucocorticosteroid production is responsible for the more severe hypokalemic alkalosis seen in malignancy-induced Cushing's syndrome than as opposed to adrenal hyperplasia.

Doctor Lennon: In three patients we have seen with primary hyperaldosteronism, all have had diabetic glucose tolerance curves. I wonder if this is related in some way to potassium depletion. Have you had occasion to measure immunoassayable insulin in such cases?

Doctor Klink: I have not been able to measure insulin in cases of hyperaldosteronism. There has been a feeling, I know, that hypokalemia in itself may be responsible in some way for the abnormal glucose tolerance seen in Cushing's syndrome. The same point has been brought up in relationship to chlorothiazide. If one administers chlorothiazide, one can produce carbohydrate intolerance in a number of people. Hypokalemia often occurs simultaneously. If one continues to give chlorothiazide, but replaces the potassium, the carbohydrate intolerance may improve. I think it is presently felt that hyperglycemia in hyperadrenocortical states is primarily the result of increased gluconeogenesis. There may be a block in peripheral utilization, but I think that it is less well supported.

Doctor Olinger: My thoughts on this case were quite similar to those outlined by Doctor Lennon. We were presented, in this patient, with a mediastinal mass and a left suprarenal mass. We had to choose between primary carcinoma in the lung producing ACTH (or an ACTH-like substance) and primary carcinoma of the adrenal cortex. We reasoned that if the patient had a primary ACTH-producing neoplasm in the chest, we would have anticipated bilateral adrenal enlargement. This proved to be a rather weak argument, as you will see. I am sorry that it did not occur to us to give this patient an ACTH stimulation test as recommended by Doctor Lennon. The question of left adrenal biopsy was raised. One of our consultants recommended bronchoscopic examination. We limited ourselves in these procedures because of the status of the patient. With widespread metastases and the outcome unquestionably bad, we felt that we could spare this lady undue or unnecessary surgical diagnostic procedures.

Sputum was studied for cancer cells and was negative. The drug used, as Doctor Lennon so cogently observed, was o-p'DDD. This was obtained for us by Dr. John Hurley, who is authorized by the National Institutes of Health to use this drug in selected cases. We used this medication for palliative purposes because, whether this lady had a primary carcinoma of the lung (or elsewhere) which was producing ACTH, or whether we had a primary carcinoma of the adrenals, we felt that most of her symptomatology was related to the Cushing's syndrome. She was considerably more comfortable when the elevated blood pressure, the hypokalemia, and the other features of the Cushing's syndrome abated. As has been found in other cases in which o-p'DDD has been used, the patient suffered only mild side reaction.

Nearly all patients have some gastrointestinal symptoms such as anorexia or nausea. Dermatologic and hematologic problems rarely arise. We wondered when this lady developed the anemia whether this might be due to the o-p'DDD. Dr. Anthony Pisciotta, who was called in consultation, felt that the changes in the marrow and the decreased half-life of the red blood cells could be explained on the basis of carcinomatosis. One of the effects of o-p'DDD which has been

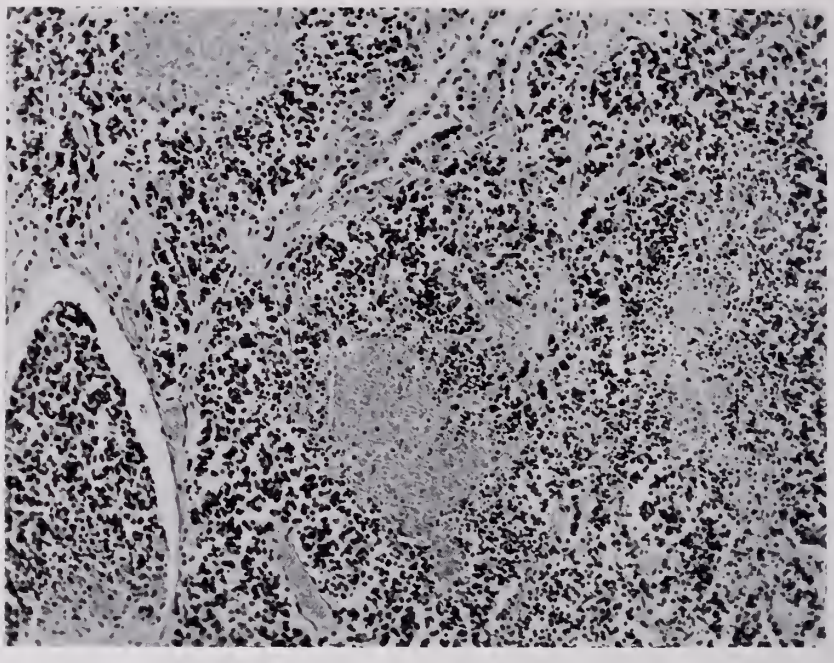

Fig. 4—Lung. Sheets of small round cells. Note tumorembolus and necrosis. x125.

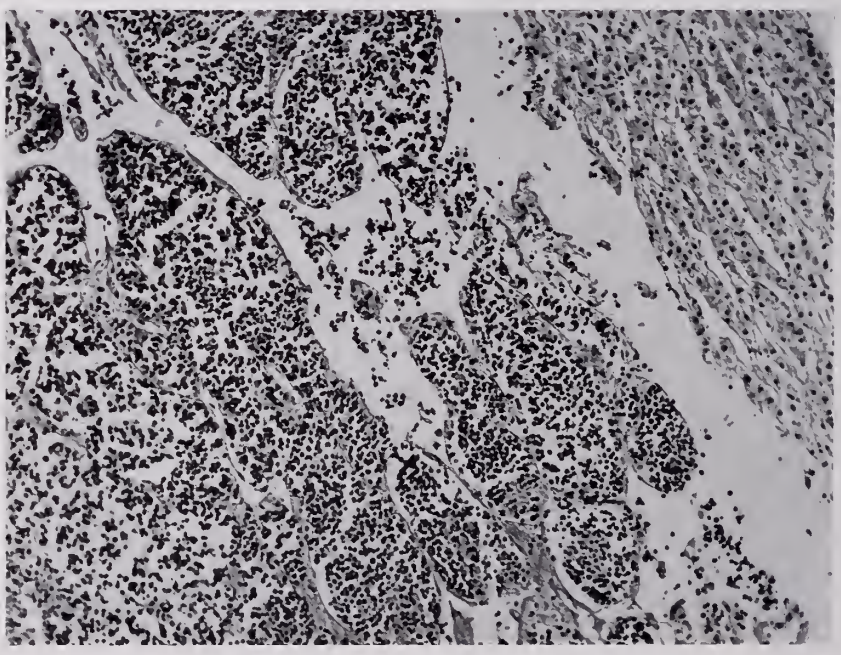

Fig. 5—Adrenal gland with metastatic tumor. x125.

reported is a drop in the PBI. Other effects on metabolism are currently under study.

Pathologic Discussion. *Dr. Carlson:* The autopsy was a most fascinating one, and the findings are multiple. Pigmentation of the skin was readily apparent. There was serous fluid in all body cavities, ranging from 400 to 800 ml. Fibrinopurulent exudate covered pleural surfaces of both lungs, more prominent on the right. The epicardium was covered with a finely granular fibrinous exudate.

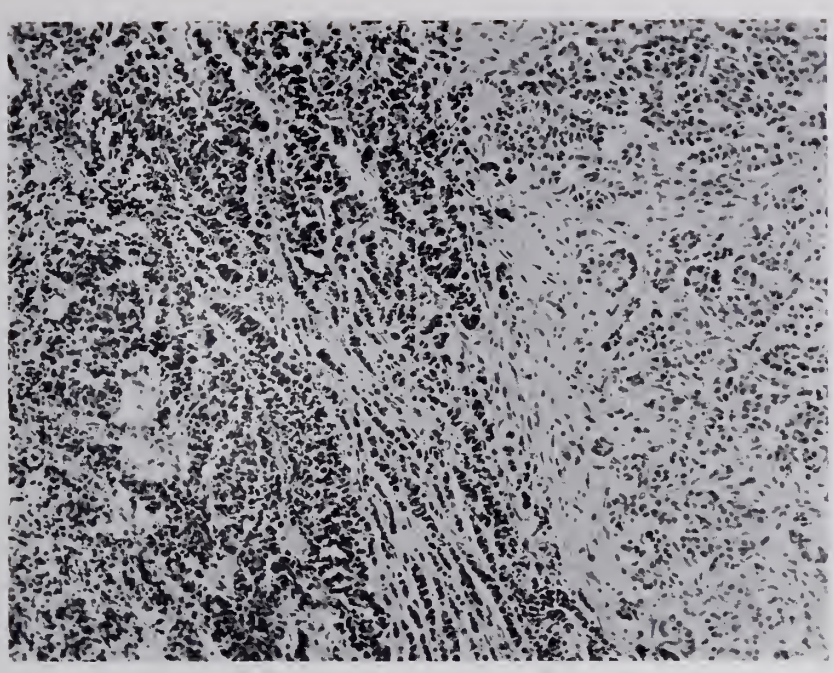

Fig. 6—Pancreas with metastatic tumor, x125.

A large, poorly defined mass occupied the left upper retroperitoneal space and epigastrium.

The heart was normal in size and configuration. The musculature was brown and the valves showed no significant change. Coronary sclerosis was mild. The lower left lung showed diffuse pneumonic consolidation. The lower right lung contained a large, hard, gritty, and partially necrotic mass of tumor. The cut surface was granular, mottled red to gray. Within adjoining lung there were two well defined abscesses filled with a foul-smelling exudate. The diaphragm was infiltrated by soft gray-white to pink tumor. Several masses of tumor were found within the liver. The body and tail of the pancreas were almost completely destroyed by tumor. The tumor in this area was fibrous, gritty, and indurated. It had extended onto the greater curvature of the stomach, and had, in fact, penetrated through the wall. A large oval ulcer was found on the mucosal surface, composed of tumor and measuring 6 to 8 cm in dimension.

The adrenals were especially interesting. Both adrenals were surrounded by soft, fleshy, encephaloid tumor. They also were enlarged, being two to three times normal size. The right had been replaced in part by soft, gray-pink, encephaloid tumor. A thickened dark orange to brown cortex was easily recognized. The left adrenal had been incorporated into the large retroperitoneal mass. Recognizable, thickened, dark orange to brown cortex was found. The retroperitoneal mass presented a varied appearance. Portions were fibrous, indurated, gray-white and mottled. In other areas it was soft, fleshy, pink to white, encephaloid, and necrotic. The remainder of the autopsy was not remarkable.

Microscopically, the tumor in all locations was composed of large nests and sheets of a small round cell (Figs 4, 5 and 6). Cytoplasm was generally scant. Nuclei were deeply stained. Mitoses were numerous. No glandular or organoid architecture was seen. The adrenal cortex was composed of large polyhedral swollen cells (Fig 7). Cytoplasm of cortical cells was vesicular, faintly stained or clear. The nuclei were small and compact. There were small microscopic foci of necrosis within adrenal cortex, accompanied by minimal hemorrhage, but no significant inflammatory infiltrate (Fig 8). Small foci of metastatic tumor removed from the major masses within adrenal glands were also seen.

Following the postmortem examination, we were faced with the problem of determining the site of primary neoplasm. Grossly and microscopically, it was not adrenal cortex. Grossly it could have been lung, pan-

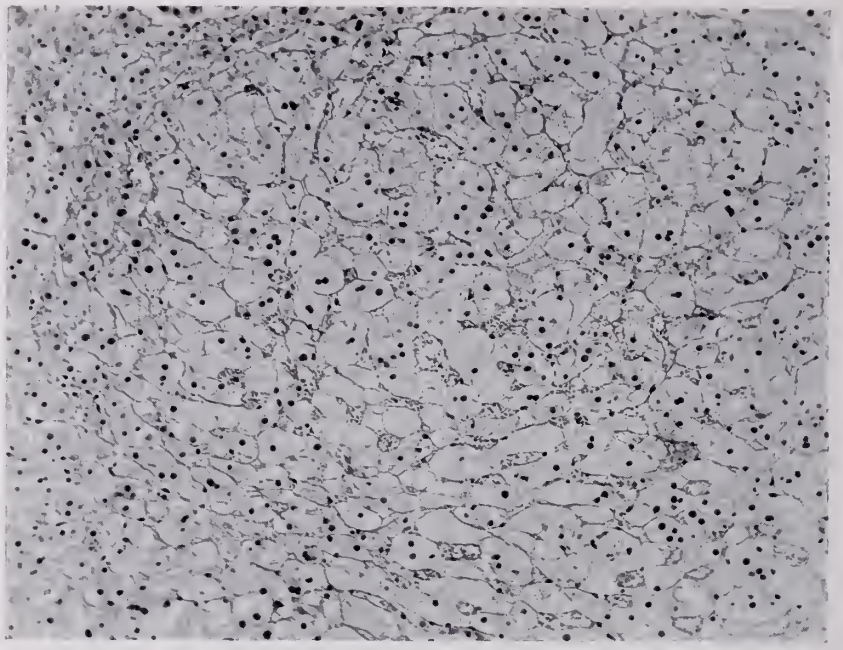

Fig. 7—Adrenal cartical hyperplasia with large pale cells. x125.

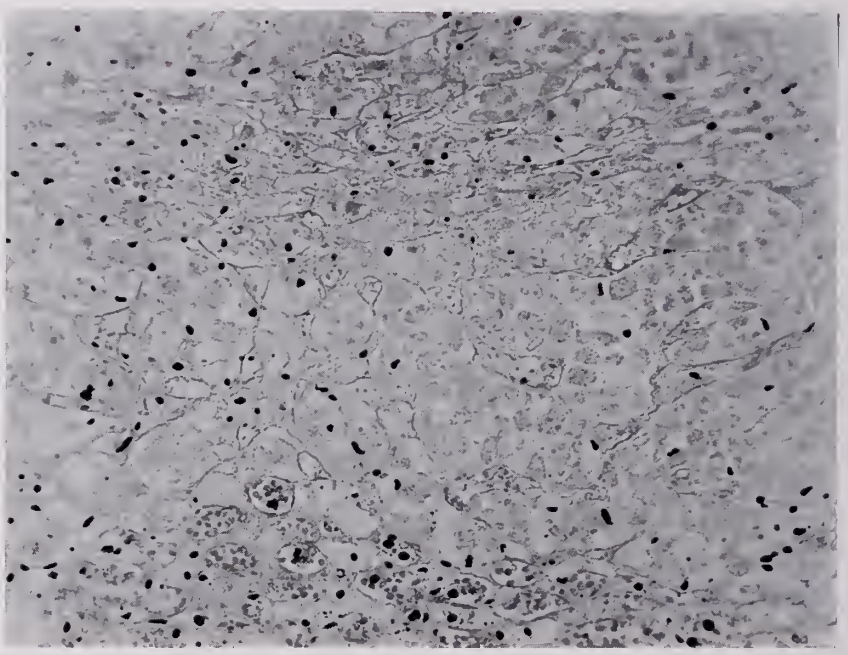

Fig. 8—Focal coagulation necrosis within adrenal cartex. x250.

creas, or stomach. Microscopically the tumor was a carcinoma composed of small round to oval cells. On gross and microscopic examination we have decided that this is primary carcinoma of the lung. Admittedly, with the great amounts of tumor in several locations, identification of the primary is difficult.

I believe, as Doctor Lennon has perspicaciously observed, that this is a case of Cushing's syndrome, secondary to primary oat-cell

carcinoma of the lung. The tumor produced ACTH or an ACTH-like substance which, in turn, was responsible for the cortical hyperplasia of adrenal gland. It is fascinating that we were able to identify microscopic foci of necrosis within adrenal cortex, histologically reflecting perhaps the observed diminution of cortical function following administration of o-p'DDD.

Doctor Lennon: I think it is most interesting that this case, like most, was of the small round cell type. When these have become as widespread as in this case, it is difficult to tell where they begin. They look alike, whether they be thymomas, tracheal node tumors, primary lung malignancies, or others. One wonders if there is something peculiar about these cells that endows them with endocrine function.

Doctor Klink: I was most interested to hear that much of the pancreas had been destroyed by metastatic tumor. Doctor Mead and I had difficulty understanding why insulin response was so limited in this patient compared to others I have demonstrated. It may have been that limited beta cell reserve, secondary to beta cell destruction, led to the limited insulin response.

Doctor Carlson: It has always been fascinating to me to find that, after a new clinical syndrome has been described, or whenever unusual or exotic complications of known disease are recognized, such cases soon appear among the material available to our medical staff. I suspect that this reflects in part what a German philosopher once said, "Was man kennt, man sieht."

2200 West Kilbourn Avenue (53233).

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STATEMENTS ON RHEUMATIC FEVER PREVENTION EXPANDED AND UPDATED BY HEART ASSOCIATION

The American Heart Association has revised and reissued three statements related to the prevention of rheumatic fever and bacterial endocarditis. The revisions were prepared by the Committee on Prevention of the Association's Council on Rheumatic Fever and Congenital Heart Disease. Titles of the statements follow:

Prevention of Rheumatic Fever, revised and reorganized for greater clarity and easier reference, also contains an expanded discussion of possible exceptions to the general recommendations for prophylaxis against recurrences.

Prevention of Bacterial Endocarditis, formerly a section of "Prevention of Rheumatic Fever", is now a separate statement. It outlines suggested treatment schedules to protect patients with rheumatic fever and congenital heart defects who are scheduled to undergo certain dental and surgical procedures.

A Method for Culturing Beta Hemolytic Streptococci from the Throat, emphasizing the importance of throat cultures in cases of suspected "strep" infections, has been expanded and updated by Lewis W. Wannamaker, a Career Investigator of the American Heart Association.

Copies of the statements may be obtained without charge from local Heart Associations or the AHA national office, 44 East 23rd Street, New York, N. Y., 10010.

NEW BOOKLET: MENTAL HEALTH

A new publication, *Research Activities of the National Institute of Mental Health,* which describes some recent advances in the Institute's mental health research program, has just been released by the Institute. More than 175 studies are mentioned in the booklet, with emphasis on activities and findings in basic, clinical and field programs of research. The publication may be ordered in bulk from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C., 20402, for 40 cents each. The Public Information Section of the National Institute of Mental Health, Bethesda, Md., 20014, will be able to provide single copies without charge while the supply lasts.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

OVID O. MEYER, M.D., Co-Editor
University of Wisconsin Medical School

Introduction of a New Editor

■ DR. OVID O. MEYER, Madison, is the newly appointed co-editor of the Comments on Treatment page. The Council of the State Medical Society has appointed him to serve with Dr. Harold F. Hardman, who became co-editor with Dr. F. E. Shideman in February 1962. Since August of 1962, when Doctor Shideman left the University of Wisconsin, Doctor Hardman has been handling the task alone, except for the first half of this year when Dr. Bert K. B. Lum, Marquette University School of Medicine, Milwaukee, took over during Doctor Hardman's leave of absence.

After 19 years as chairman of the Department of Medicine, University of Wisconsin Medical School, Doctor Meyer resigned last summer in order to devote full time to teaching, investigation, and his patients. Prior to accepting the chairmanship, he had been a professor in the Department of Medicine.

Dr. O. O. Meyer

A native of Stevens Point, he received his academic education, with the B.S. degree, at the University of Wisconsin, and in 1926 obtained his medical degree from Columbia University College of Physicians and Surgeons, New York City. He interned at Wisconsin General Hospital, Madison, in 1926–1927, and served a medical residency from 1927 to 1929 at the same hospital, where later he was to become chief of medical service. The foundation for Doctor Meyer's later development was broadened by service at Huntington Memorial Hospital and Thorndike Memorial Laboratory, Boston, from 1929 to 1932. Returning to the University of Wisconsin in 1932, he rose steadily to full professorship (1944) and chairmanship of the Department of Medicine (1945). In 1950 he was one of 29 civilian physicians who participated in the Army Medical Department Overseas Consultant Program. His tour of duty took him to Europe.

He is certified by the American Board of Internal Medicine and is a member of the American College of Physicians, the Association of American Physicians, the American Society for Clinical Investigation, the Central Society for Clinical Research, the Dane County Medical Society, which he served as president in 1950, the State Medical Society of Wisconsin, to which he was a delegate from his county society in 1951–1952, and the American Medical Association. In the last named he has served with distinction on the Council on Drugs and as chairman of the Section on Internal Medicine. He is currently a member of the State Medical Society's Commission on Scientific Medicine.

Doctor and Mrs. Meyer live at 1806 Summit Avenue, Madison.

At their 1964 reunion, the U.W. Medical School Class of '44 honored Doctor Meyer by contributing to the establishment of a new program in support of "Research in Educational Methodology in Clinical Medicine." This tribute bears eloquent testimony to his profound influence as a teacher and leader. Furthermore, his sustained contributions to the knowledge of disorders of the blood-lymph system and to the use of anticoagulants eminently qualify him as co-editor of the important "Comments on Treatment."

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Real Alternate

■ THE *Saturday Review* of March 6, 1965, previewed a book by William Glasser, M.D., of Los Angeles Orthopaedic Hospital, entitled "Reality Therapy" (Harper & Row), which should prove of great interest to most doctors in private practice. The book attacks some of the basic concepts of the Freudian psychoanalytic theory that interpret asocial and antisocial behavior as "mental illness," thereby avoiding the problem of morality in cases of deviant behavior.

With the increasing application of Freudian-oriented disciplines to the management of our social establishments, many serious scientists have flinched at the idea that the criminal, the juvenile delinquent, the socially irresponsible person, and even those who are hard to get along with, are merely mentally ill and therefore not to be held morally responsible for their actions. Proceeding on an analogy with physical illness, conventional psychotherapy refers deviant behavior to unconscious mental conflicts which are considered more important than present problems. It assumes that once the patient gains insight into the nature of his emotional conflicts, he will somehow correct his behavior as a natural consequence of his insight.

On a practical level, this attitude has produced a lenient, permissive approach to serious social problems. The morality of criminal acts is less important than the traumatic experiences that are believed to have produced the emotional conflicts leading to the acts. Bad boys are simply sick boys, and once their mental illnesses are treated, they will recover their mental health and behave in a socially acceptable manner.

Doctor Glasser, according to the statement he wrote in the *Saturday Review*, does not accept the concept of mental illness; the patient must accept full responsibility for deviant behavior. Unlike conventional therapists, the practitioners of what he calls Reality Therapy establish a proper involvement with the patient in what seems to be a teaching relationship. The Reality therapist does not attempt to isolate unconscious conflicts or their reasons: instead he attacks present problems specifically and works toward the future. Morality of behavior is stressed, and the patient is helped to find more satisfactory patterns of behavior which

Views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

will in turn enable him to form an attitude of self-respect toward himself.

The new element in Doctor Glasser's system is the introduction of morality and ethics into an area from which such considerations have been consciously withdrawn. Since correction of behavior is the purpose of psychiatric therapy and since every humanly willed action is evaluated in terms of a system of morality, it appears reasonable that philosophic criteria cannot be absent from psychotherapy.

Most importantly, from Doctor Glasser's short article it appears that individual responsibility is again enthroned in the human mind, and man is again rescued from an indeterminism of accident and restored to the mastery of his own will. In these times when man is in greater than ever control of his own environment, it is essential that he be in greater control of his own will.

Without belittling the alleviation of human suffering that has come from Freudian psychiatry and the value that it will continue to have in the understanding of human behavior, many doctors will find the common-sense approach of Doctor Glasser's Reality Therapy a valuable technique in the treatment of deviant behavioral problems. Whether or not it has universal application, it should receive serious study as a therapeutic modality for inclusion in the physician's armamentarium. —D.N.G.

Salute!

■ HEALTH CARE services boast of many unsung heroes—and heroines—and foremost in the ranks are the ladies of the hospital auxiliary groups. These are the public-spirited volunteers whose dedication to the welfare of the community is more than a charitable contribution of money; these are the ladies who pitch in their time and their energy to get things done that money can't buy.

The various hospital auxiliary organizations perform a vital function by raising funds for hospital requirements. They provide many important items of scientific equipment, as well as the conveniences, that the major sources of hospital funds cannot supply. But more importantly, by operating the portable canteens, transporting patients to and from laboratories, staffing the information desks, distributing mail, serving in the coffee shops and doing many of the clerical details, they help keep the cost of hospital care from rising even higher.

By performing many tasks skillfully, devotedly and conscientiously, they make hospital visits much more pleasant for patients. Without them and their quiet service, institutional life would indeed be dreary and difficult. For theirs is a labor of love, a work arising from motives of pure altruism.

Although no applause can repay them for what they do, the ladies of the hospital auxiliaries deserve much appreciation for their work. Members of the medical profession must salute these fine volunteers who give of themselves for the welfare of their community. Their charity is of the purest kind.

Ladies, our heartfelt thanks to you all, individually and collectively. —D.N.G.

The Doctors Plan

■ IT SHOULD BE a cause of great pride to members of the State Medical Society that Wisconsin Physicians Service is one of the seven Blue Shield Plans in the United States to increase its enrollment more than 20%. WPS membership during 1964 shot up 20.08% with the addition of 63,885 new enrollments. Total WPS membership is currently in excess of 382,000.

Dr. E. M. Dessloch, chairman of the Society's Commission on Medical Care Plans, explained that, "This result is in keeping with the service-to-mankind concept of medicine, in that doctors concern themselves not only in dispensing medical care, but also with making sure that those needing care are not financially burdened by it." And as proof of this ideal of integrated medical service, WPS reports 90¢ of each premium dollar it received was returned to its members in the form of subscriber benefits.

These few facts are worth remembering when discussing medical insurance with your patients. The effectiveness of WPS is demonstrated by its growth. It merits your support. —D.N.G.

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GUEST EDITORIAL

First Aid for Doctor—Patient Relationship

■ AS I LOOK OVER the fifty years I have devoted to the practice of medicine, the fact that concerns and saddens me most is the deterioration of doctor-patient relationship. This is exemplified by the strong demand for government control of medicine and the frequency of malpractice suits (recent reports by A.M.A. indicate that one doctor in six can expect a suit), also the doctor strikes in Belgium and Saskatchewan. Many of you remember the public image of the older doctor —highly respected and admired, a leader in his community. He was with patients through birth to death and was a great solace at time of bereavement. He was on the job 24 hours a day and 7 days a week. Without benefit of laboratory, he used his five senses and his knowledge of human nature to aid him in diagnosis and in general did a good job. He gave the impression that his main interest was not what medicine could do for him, but what he could do for medicine. It was unthinkable that his patients would want him to be government controlled or to consider filing a malpractice suit against him.

What has happened today? Living as we are in a scientific age with remarkable advances in surgery, drug therapy, and in the treatment of mental diseases, it was inevitable that scientific training would receive emphasis in the education of medical students with neglect of the training in the art of medicine. Medical schools are turning out doctors who are trained to the finger tips in laboratory diagnosis, but lacking knowledge of human relationships in many respects. When these highly trained men consider a location for practicing medicine, they first consult their wives who decide whether the social and educational advantages are suitable. Then the doctor himself considers the recreational offerings of the community. Next he prefers association with a group of doctors at a large salary—with days off and minimum of night work. With his lack of training in the art of medicine, he fails to realize what a picture he is creating in the public mind. An impression is given that his main interest is not in medicine or the patient, but in using medicine only as a means to an end. Add to this the tremendous cost of illness and it is easy to understand the change in public opinion of the medical profession today.

The pendulum has swung too far to expect any return to the old doctor image, but some effort on the part of medical schools to teach the art as well as the science of medicine would help. The appointment of a general practitioner to the staff of a medical school to lecture on the art and not the science of medicine would equip these students to handle patients from the public relations standpoint. The medical profession has no one to blame but itself for the present situation. If anything can be done to restore the old doctor image, it will not come from the organized bodies such as the A.M.A., state or local societies, it must come from the individual doctor himself. He must convey the impression that he is primarily interested in what he can do for medicine and not in what medicine can do for him.

—W. J. TUCKER, M.D., Ashland

LETTERS

AN ALTERNATIVE?

To the EDITOR:

I wish to protest the editorial (Regulation Needed) in the April issue of the JOURNAL.

People who know most about this problem know that such legislation as has been proposed in the JOURNAL will only inconvenience legitimate gun owners but will have absolutely no effect in disarming criminals.

Congressman Bob Casey of Texas has introduced a bill in the 89th congress (H. R. 5642) which provides that "Whoever, during the commission of any robbery, assault, murder, rape, burglary, kidnaping or homicide (other than involuntary manslaughter) uses or carries any firearm which has been transported across the boundary of a state, the District of Columbia, or a territory or possession of the United States shall be imprisoned for 25 years."

This is the type of legislation which is needed. This would really help in disarming criminals and misfits.

N. A. EIDSMOE, M. D.
Rice Lake, Wis.

NEW PRESIDENT—Dr. W. P. Curran, left, Antigo, congratulates Dr. J. H. Houghton, Wisconsin Dells, on assuming the presidency of the State Medical Society.

PRESIDENTIAL CITATION—Dr. W. P. Curran, left, Antigo, presents the Presidential Citation to Harvey V. Higley, Morinette, former Administrator of Veterons Affairs.

SUMMARY REPORT

124TH ANNUAL MEETING

HOUSE OF DELEGATES

Milwaukee, May 3–6, 1965

The Annual Meeting of the House of Delegates was held May 3–6 in Milwaukee, with the House considering six resolutions and 20 reports and supplementary reports of Officers, the Council, Divisions, Committees and Commissions of the Society.

Focus on "Medicare"

Keynote of the session was expressed by J. H. Houghton, M.D., Wisconsin Dells, incoming president, as he addressed the House at the opening session:

> "If 'medicare' becomes a law, and it looks like it will . . . we will be faced with a new way of medicine for at least a segment of our population . . .
>
> "The only thing we can do, in all good conscience, is to try to give the American people the same caliber of medical care to which they have been accustomed under the free enterprise system."

Doctor Houghton also suggested, and the House concurred, that the Society investigate development of voluntary insurance programs to fill the gaps left by current proposed federal legislation for those 65 and over.

"Medicare" continued to receive attention in the second session of the House as James C. Fox, M.D., La Crosse, Chairman of the Council, informed Delegates of an American Hospital Association campaign to place the services of pathologists, anesthesiologists, radiologists and physiatrists under the hospital services section of the bill. (As passed by the House of Representatives, services of these physician specialists are not included, but efforts are to have them added as the Senate considers the bill.)

Radiology

Meeting Wednesday, following conclusion of the House session, the Council received a resolution adopted by the Wisconsin Radiological Society stat-

DISTINGUISHED THREESOME—President J. H. Houghton, Wisconsin Dells; President-elect F. E. Drew, Milwaukee; and Immediate Past President W. P. Curran, Antigo.

AMA-ERF CHECKS—Dr. P. B. Blanchard, right, Cedarburg, chairman of the AMA-ERF, presents grants totaling more than $30,000 to Wisconsin's two medical schools. Accepting the grants are, left to right, Dr. John S. Hirschboeck, vice-president of Marquette University, and Dr. James Crow, Ph.D., then acting dean of the University of Wisconsin Medical School.

ing that after January 1, 1966, Wisconsin radiologists should bill fees for their professional services to patients and that charges for technical services connected with radiology should be billed by the institution, group or individual providing such technical services. It further requested the Council of the Society to advise the Wisconsin Hospital Association that contractual agreements between hospitals and radiologists should be revised to conform with the principles stated in the resolution. The Council approved the action in principle and agreed to use the good offices of the Society to arrange such conferences as will be necessary to implement it.

Mental Health Programs

Mental Health programs and planning, as outlined by the Division on Nervous and Mental Diseases of the Commission on State Departments, received considerable attention with the result that the House directed additional staff assistance for the Division to assure comprehensive representation in the vast number of private and governmental programs being carried on in the field of mental health. Resolution No. 4 (Brown County) calling for a full time staffman to work in the field of mental health, and if necessary increasing dues to finance this staff activity, was rejected since the House did not wish to establish the precedent of designating full time individual staffing for any particular function of the Society.

Resolutions

No. 1—(Richland County) Establish a chair of general practice on the staffs of the two Wisconsin medical schools and a general practice residency or rotating internship at involved hospitals. Rejected at this time, while recognizing the existing shortage of general practitioners, since the matter is being studied by national organizations.

No. 2—(Manitowoc County) Recommend that hospital staff bylaws contain a provision that a physician have right to hearing, counsel and receive written notice before an appointment to the staff be revoked, withdrawn, suspended, canceled or not renewed. Approved.

No. 3—(Sheboygan County) Substitute resolution declaring that physicians should be free to provide medical care according to their best scientific and moral judgment, the intimacy and privacy of the doctor-patient relationship be preserved, free choice of physician be continued, and that doctors of medicine

COUNCIL AWARD—Dr. James C. Fax, left, La Crosse, presents the Council Award to Dr. Carl N. Neupert, Madison, retiring State Health Officer.

should be represented fully on all boards and committees empowered to direct and supervise general administration of medical care for the aged including amount and distribution of fees, selection and approval of hospitals and nursing homes. The Council was urged to study the role of the Society in implementing the resolution. Approved.

No. 4—(Brown County) Society engage full time staffman for field of mental health. Rejected. (See discussion of mental health activity above.)

No. 5—(Douglas County) The Interim Meeting of the House, now on an annual basis, be held in abeyance and called only at the request of the President, Speaker or Council. Rejected at this time.

No. 14—(Bylaw amendment held over from October, 1965) Amend the Bylaws to include voluntary surrender of license as a circumstance whereby membership automatically terminates. Approved.

ELVEHJEM MEMORIAL LECTURE AWARD—Receiving an award for presentation of the Elvehjem Memorial Lecture from Dr. W. P. Curron, right, Antigo, is Dr. John B. Henry, Syracuse, N. Y.

Constitutional Amendments

1. Provides for special sessions of the House called by the Speaker on written request of twenty Delegates representing 10 per cent or more of the component county medical societies, or on request of a majority of the Council. Approved.
2. Limiting the terms of Councilors to three successive three-year terms wherever possible, and a total of no more than six terms. Approved.

WILLIAM BEAUMONT MEMORIAL LECTURE AWARD—Dr. Alton Ochsner, New Orleans, La., receives award denoting the William Beaumont Memorial Lecture from Dr. W. D. Stovall, Madison, president of the CES Foundation which sponsors the annual lecture.

FIFTY YEAR CLUB—Members of the Fifty Year Club present at the annual dinner to receive their awards were front row, left to right: E. O. Ravn, Merrill, and H. M. Carter, Madison; and back row, left to right: W. E. Buckley, Racine, and C. H. Andrew, Platteville. Other members of the Club are: Drs. R. T. Cooksey, Madison; Q. H. Danforth, Oshkosh; J. A. Fleischmann, Milwaukee; G. W. Huber, Minaqua; D. F. Hudek, Bloomer; M. L. Jones, Wausau; B. F. Kraus, Sauk City; J. D. Leahy, Park Falls; R. L. MacCornack, Sr., Whitehall; J. E. Rueth, Milwaukee; and E. L. Tharinger, Milwaukee. Brief biographical sketches of these doctors appear in the news section of this issue.

NOMINATING COMMITTEE—Seated, left to right: Drs. C. E. Koepp, Marinette; E. F. Castaldo, Laona; W. D. Hamlin, Mineral Paint; C. J. Picard, Superior; E. C. Quackenbush, Hartford; L. O. Simenstad, Osceola; R. N. Allin, Madisan. Standing, left to right: Drs. E. C. Glenn, Port Edwards; E. P. Rahde, Galesville; Morris Siegel, Kenosha; R. P. Bergwall, Milwaukee; and Paul LaBissoniere, Wauwatosa.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Left to right: Drs. E. D. Sarensan, Elkhorn; C. J. Strang, Barran; M. V. Overman, Neillsville; H. F. Twelmeyer, Wauwatosa; and L. W. Schrank, Waupun.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Left to right: Drs. G. W. Hilliard, Milwaukee; W. F. Henken, Racine; W. T. Russell, Sun Prairie; D. J. Twahig, Fond du Lac; and C. A. Grand, Ashland.

Actions

On the basis of reports from the Council, Divisions, Committees and Commissions of the Society, the House:

1. Endorsed a statement filed with the State Department of Administration urging that it revise salary schedules for state employed physicians in the interest of attracting and holding physicians in public health positions.
2. Offered cooperation to the State Department of Public Welfare in a federal program of health counseling to those not accepted by the Armed Forces for health reasons, providing administration is conducted in a way not to disturb normal patient-physician relationships.

3. Authorized Society sponsored workshops on re-employment of the retired and medical aspects of nursing home care.
4. Approved continuation of conferences on the relationships between medical educators and physicians in private practice.
5. Recommended that the State Mental Health Advisory Committee have adequate physician representation at all times.
6. Approved a statement on nurse responsibility in maternal and child care.
7. Declared or reaffirmed legislative support for:
   a. Principle of requiring reporting of cases of suspected child abuse, providing immunity is guaranteed for the reporting physician.
   b. Testing for phenylketonuria and making PKU a reportable disease, but not favoring making medical procedures mandatory by legislative action.
   c. Changes in the Basic Science Law to add chemistry and bacteriology as examination subjects, and increasing the per diem paid to board members.
   d. Principle of "implied consent" for chemical tests for intoxication, referring specific legislative proposals to the Commission on Public Policy.
8. Declared or reaffirmed legislative opposition to:
   a. Use of title "doctor" by chiropractors.
   b. Proposed law on labeling of dangerous drugs on the ground that it is already covered in Wisconsin law.
   c. Bill providing that non-profit sickness insurance organizations be subject to domestic insurance corporation laws.

SPECIAL SCIENTIFIC AWARDS, recognizing their service to the Maternal Mortality Study Committee of the Society, were presented to, left to right, Dr. T. A. Leonard, Madison, and Dr. F. J. Hafmeister, Milwaukee, by Dr. John Evrard, Milwaukee, chairman of the Division on Maternal and Child Welfare of the Commission on State Departments. A third recipient, Dr. G. S. Kilkenny, Milwaukee, was unable to be present because of illness. The awards, in the form of lamps incorporating the bust of Aesculapius and the Hippocratic Oath, were presented by the Council on Sunday, May 2, in Milwaukee.

9. Tabled Resolution No. 25 (Waupaca County) from the May, 1964 meeting, dealing with the report form sent to those examined at State Board of Health mobile units.
10. Tabled Resolution No. 1 (Fond du Lac County) from the October, 1963 meeting concerning relations with the State Department of Public Welfare.

Dr. G. S. Kilkenny

PAST PRESIDENTS—Seated, left to right: Drs. F. E. Drew, Milwaukee, president-elect; J. H. Haughton, Wisconsin Dells, president; W. P. Curran, Antigo, immediate past president; E. L. Bernhart, Milwaukee; H. E. Kasten, Beloit; and N. A. Hill, Madison. Standing, left to right: Drs. K. A. Doege, Marshfield; W. D. Stovall, Madison; Gunnar Gundersen, La Crosse; E. D. Sorenson, Elkhorn; W. J. Egan, Milwaukee; M. A. McGarty, La Crosse; R. P. Sproule, Milwaukee; A. J. McCarey, Green Bay; J. C. Griffith, Milwaukee; and H. K. Tenney, Madison.

Reports

COMMISSION ON SCIENTIFIC MEDICINE: In-Depth Teaching Programs—five programs serving 305 physicians. Circuit Teaching Programs—two circuits, six programs serving 161 physicians. Speakers Service—50 county medical society meetings and several Councilor District meetings. Psychiatry In General Practice—two programs serving 39 physicians. Experimental Open Circuit Television Programs—eight programs serving 834 physicians. The Commission indicated an interest in FM radio broadcasts, with two-way communication to enable listeners to question the speakers.

COMMISSION ON MEDICAL CARE PLANS: Completed negotiation with Office of Dependents' Medical Care to retain the principle of "customary, usual and reasonable" fees and notified the Veterans Administration that the present contract with them would be renewed only with the inclusion of "customary, usual and reasonable" fee basis. Reported earned premiums of $15,359,000 for WPS in 1964, an increase of $2,120,000. Expanded claims payments of $2,300,000 to nearly $14,000,000 in the same period. Added $73,000 to reserves.

WISCONSIN WORK WEEK OF HEALTH: Week-long series of conferences held in February, 1965, with 34 cosponsoring organizations, attended by 1,380 state and community leaders, with extensive publicity carrying conference proceedings and actions and policies of the Society to thousands more.

Elections and Appointments

President—J. H. Houghton, M.D., Wisconsin Dells (1965–66)

President-Elect—Frank E. Drew, M.D., Milwaukee (1965–66)

Speaker—R. E. Callan, M.D., Milwaukee (1965–67)

Vice-Speaker—G. A. Behnke, M.D., Kaukauna (1965–66)

AMA Delegates—W. B. Hildebrand, M.D., Menasha (1966–67); and R. E. Galasinski, M.D., Milwaukee (1966–67)

AMA Alternates—G. E. Collentine, Jr., M.D., Milwaukee (1966–67); and Nels A. Hill, M.D., Madison (1966–67)

COUNCILORS

3rd District—M. D. Davis, M.D., Milton (1965–68)

4th District—H. W. Carey, M.D., Lancaster (1965–67)

6th District—George Nadeau, M.D., Green Bay (1965–68)

7th District—James C. Fox, M.D., La Crosse (1965–68)

8th District—J. W. Boren, Jr., M.D., Marinette (1965–68)

PHOTOGRAPHY EXHIBIT—The Best-of-Show photograph by Dr. Leo Grinney of Racine is viewed by Dr. Gunnar Gundersen of La Crosse, right, and one of the special guests from out of state. The photograph exhibit drew some 50 entries.

MEDICAL ART SALON—A Milwaukee physician and his family view the first place winner in the Oils division of the art show contest sponsored by the Woman's Auxiliary to the State Medical Society. It was painted by Dr. William Havis of Milwaukee and its title is "Untitled."

Second place winner in the Oils division was Dr. Victor Neu of Green Bay whose painting was titled "Still Life." Mrs. Sheba Jacobson of Milwaukee placed third with her painting, "Landscape." Honorable mention was given to Joan Wills of Milwaukee for her painting, "The Sad, the Pensive Hour."

Winners of the Water Color division were: first, Mrs. P. D. Christensen, Green Bay, "Still Life;" second, Dr. Milton Gutglass, Milwaukee, "Still Life;" third, Mrs. Joan Holzgroefe, Milwaukee, "Still Life;" and honorable mention, Dr. George Gutmann, Janesville, "Storm Clouds over Wisconsin Lake."

In the Sculpture division, Dr. Milton Gutgloss, Milwaukee, received honorable mention for his sculpture entitled "Head."

AMA Television Program on ABC-TV June 17

6:30 P.M.—Madison WKOW-TV & Wausau WAOW-TV

"Your Doctors Report on Health Care at the Crossroads"—Dr. Donovan F. Ward and Dr. Edward R. Annis.

SCIENTIFIC EXHIBIT—Best in show: Diagnosis and Treatment of Pulmonary Thrombo-Embolism, by Drs. R. D. Sautter and Dean A. Emanuel, Marshfield Clinic Foundation for Medical Research and Education, Marshfield Clinic, Marshfield.

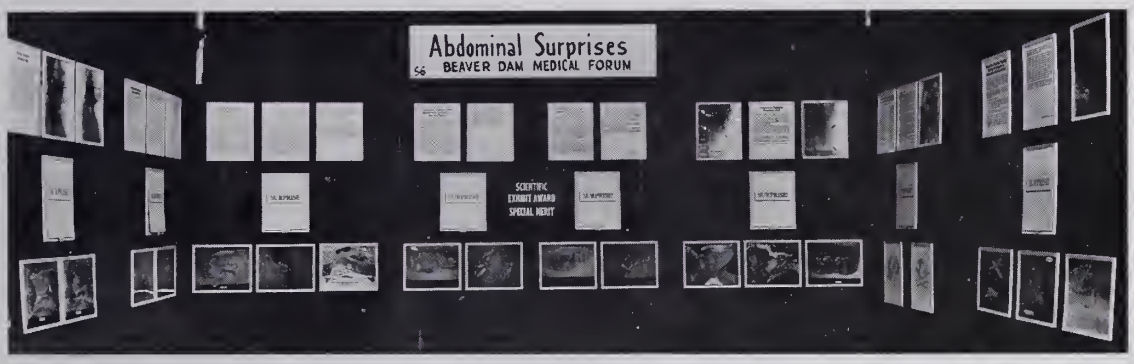
SCIENTIFIC EXHIBIT—Special merit: Radioisotope Organ Scans, by Drs. R. C. Meade and Philip Ruetz, Veterans Administration Medical Center, Wood (Milwaukee).

9th District—E. P. Ludwig, M.D., Wausau (1965–68)
10th District—W. R. Manz, M.D., Eau Claire (1965–68)
12th District—S. L. Chojnacki, M.D., Milwaukee (1965–68); and S. W. Hollenbeck, M.D., Milwaukee (1965–68)
13th District—Marvin Wright, M.D., Rhinelander (1965–68)

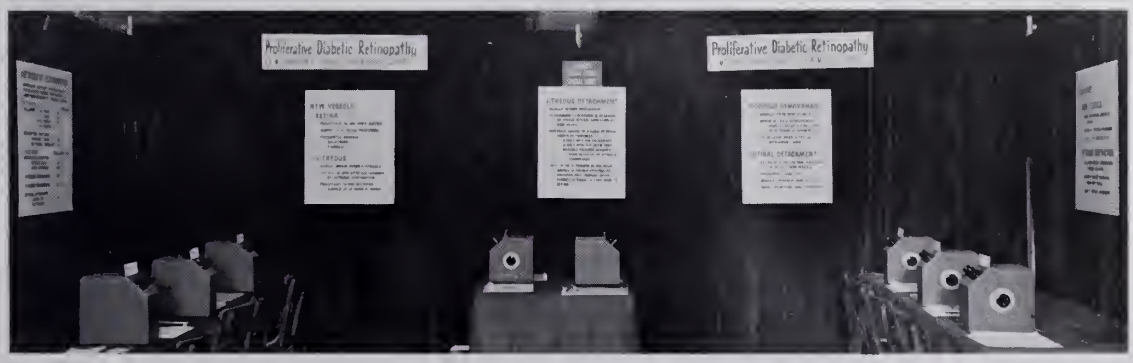
COMMISSION ON STATE DEPARTMENTS (One-Year Terms)

Chairman—T. W. Tormey, Jr., M.D., Madison
Vice-Chairman—W. J. Egan, M.D., Milwaukee
Aging—A. M. Hutter, M.D., Fond du Lac
Chest Diseases—H. A. Anderson, M.D., Stevens Point
Handicapped Children—J. W. Nellen, M.D., Green Bay

SCIENTIFIC EXHIBIT—Special merit: Diagnosis of Stomach Lesions with Gastro Camera, by Dr. James R. Hoan, Sheboygan Clinic, Sheboygan.



SCIENTIFIC EXHIBIT—Special merit: Abdominal Surprises, by the Beaver Dam Medical Forum, Beaver Dam.



SCIENTIFIC EXHIBIT—Special merit: Proliferative Diabetic Retinopathy, by Dr. M. D. Davis and associates, University of Wisconsin Medical School, Madison.

Maternal and Child Welfare—John R. Evrard, M.D., Milwaukee
Nervous and Mental Diseases—C. A. Wunsch, M.D., Green Bay
Public Assistance—H. W. Carey, M.D., Lancaster
Rehabilitation—Paul A. Dudenhoefer, M.D., Milwaukee
Safe Transportation—Richard B. Windsor, M.D., Sheboygan
School Health—James C. H. Russell, M.D., Ft. Atkinson
Visual and Hearing Defects—Meyer S. Fox, M.D., Milwaukee

COMMITTEE ON CANCER (Three-Year Terms)

G. A. Smiley, M.D., Delavan; R. C. Glise, M.D., Richland Center; R. C. Frank, M.D., Eau Claire; G. I. Uhrich, M.D., La Crosse; J. F. Brown, M.D., Rhinelander; and J. J. Gramling, Jr., M.D., Milwaukee. Doctor Smiley appointed Chairman and Doctor Glise Vice-Chairman for one-year terms.

COMMITTEE ON GRIEVANCES (Three-Year Terms)

E. D. Sorenson, M.D., Elkhorn; R. W. Mason, M.D., Marshfield; and E. W. Mason, M.D., Milwaukee. Doctor Sorenson appointed Chairman and J. D. Leahy, M.D., Park Falls, Vice-Chairman for one-year terms.

COMMISSION ON PUBLIC POLICY

L. J. Kurten, M.D., Racine (Five-Year Term); R. L. Gilbert, M.D., La Crosse; J. B. Durst, M.D., La Crosse; P. K. Odland, M.D., Janesville; A. D. Anderson, M.D., Madison; S. A. Freitag, M.D., Janesville (Three-Year Terms); and L. W. Schrank, M.D., Waupun; T. E. Henney, M.D., Portage (Two-Year Terms). W. T. Russell, M.D., Sun Prairie, appointed Chairman and C. F. Broderick, M.D., Wisconsin Dells, Vice-Chairman for one-year terms.

COMMISSION ON SCIENTIFIC MEDICINE (Five-Year Terms)

J. A. Killins, M.D., Green Bay; and R. A. Starr, M.D., Viroqua. The Commission selects its own Chairman.

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION (Three-Year Terms)

M. V. Overman, M.D., Neillsville; A. J. Richtsmeier, M.D., Madison; and R. S. Galgano, M.D., Delavan. G. B. Murphy, Jr., M.D., La Crosse, appointed Chairman for a one-year term.

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS (Three-Year Terms)

C. J. Picard, M.D., Superior; R. G. Hansel, M.D., Baraboo; and R. R. Rueckert, M.D., Portage. D. E. Dorchester, M.D., Sturgeon Bay appointed Chairman and R. J. Botham, M.D., Madison, Vice-Chairman for one-year terms.

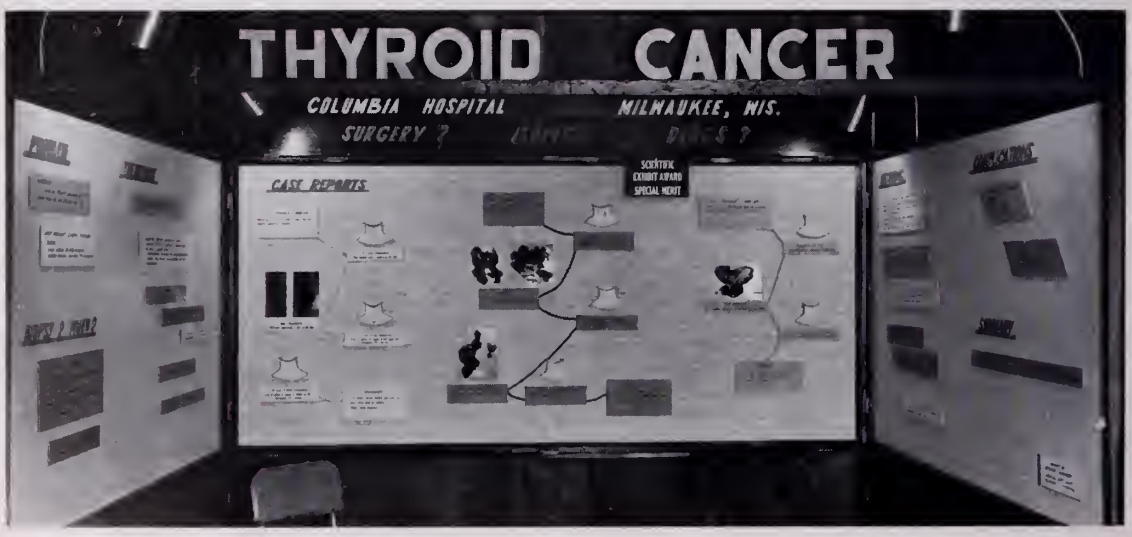
COUNCIL ELECTIONS (One-Year Terms)

Chairman—James C. Fox, M.D., La Crosse
Vice-Chairman—E. J. Nordby, M.D., Madison
Treasurer—F. L. Weston, M.D., Madison
Assistant Treasurers—H. Kent Tenney, M.D., Madison; N. A. Hill, M.D., Madison; J. T. Sprague, M.D., Madison; and E. J. Nordby, M.D., Madison
Editorial Director—D. N. Goldstein, M.D., Kenosha

Honors and Awards

Council Award—C. N. Neupert, M.D., Madison, State Health Officer
Presidential Citation—Harvey V. Higley, Marinette, former Administrator of Veterans Affairs
Special Scientific Awards—T. A. Leonard, M.D., Madison; F. J. Hofmeister, M.D., Milwaukee; and G. S. Kilkenny, M.D., Milwaukee, for continuous service on the Maternal Mortality Study Committee since 1951.

SCIENTIFIC EXHIBIT—Special merit: Treatment of Thyroid Cancer, by Drs. P. H. Seefeld and J. O. Chamberlain, Columbia Hospital, Milwaukee



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COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

Seventeen members attended the meeting of the Ashland–Bayfield–Iron County Medical Society May 11 in Ashland.

The scientific program was presented by Dr. L. Aaro of the Mayo Clinic Obstetrical and Gynecological Department. He used slides to illustrate his talk on "Thrombophlebitis in Pregnancy." Society president, *Dr. R. J. Sneed,* appointed a fee schedule committee of three members: *Dr. J. W. Prentice,* chairman, *W. E. Bargholtz* and *J. M. Jauquet,* after Doctor Bargholtz spoke of the need for revamping the fee schedule for welfare patients and private physicians of the area. *Dr. C. A. Grand,* delegate, gave a resumé of the annual meeting of the State Medical Society in Milwaukee.

BROWN

Dr. Robert McCollough, epidemic intelligence service officer of the National Institutes of Health, discussed the investigation of leukemia now under way at the NIH at the May 20 meeting of the Brown County Medical Society. During the business meeting which preceded the society's dinner in Green Bay, delegates to the State Medical Society reported on the annual meeting of the House of Delegates.

CALUMET

The Calumet County Medical Society and the health committee of the Calumet County Board of Supervisors sponsored a smallpox vaccination program April 29 and 30 and May 3, 4 and 5 for children from kindergarten through third grade in all Calumet County schools.

DOUGLAS

Thomas A. Plant, Social Security Administration district director from Superior, spoke on the subject "Social Security Present and Future" at the meeting of the Douglas County Medical Society May 12 in Superior. Mr. Plant discussed pending legislation to cover physicians.

Money raised by the society and the Superior Junior Chamber of Commerce at the polio clinics was placed in a memorial fund to be used for scholarships for a student in medicine and allied sciences at Wisconsin State University, Superior.

FOND DU LAC

Clergymen of all faiths were guests at a Fond du Lac County Medical Society meeting for the first time in the organization's 97-year history when the society met May 18 in Fond du Lac.

Dr. F. J. Cerny was program chairman, and moderator of a panel discussion by four clergymen of different faiths and four physicians of different faiths and in various branches of medicine. Following dinner, a short introductory talk was given by Robert Etheridge, staff member of the Department of Medicine and Religion of the American Medical Association.

GREEN

The Green County Medical Association took a stand against skateboards in May after a 15-year-old girl suffered a fractured leg while indulging in the current fad. In an advertisement in the May 14 edition of the MONROE EVENING TIMES, the society cautioned against using the boards because of the danger involved. Society spokesman is *Dr. Benjamin Brunkow,* president of the organization.

KENOSHA

The Kenosha County Medical Society meeting scheduled for May 6 was postponed until May 18 because of a conflict with the State Medical Society's annual meeting. The program, by Don Ricci, was on the subject, "The Physician and the Special Education Team."

PIERCE–ST. CROIX

A total of 2,137 students took advantage of the immunization program sponsored this past spring by the Pierce County Public Nursing Service in cooperation with the Pierce–St. Croix County Medical Society. A total of 1,573 students received diphtheria tetanus protection and 937 students received smallpox protection.

PRICE–TAYLOR

The annual congenital and rheumatic heart disease clinic held in April at the Park Falls Memorial Hospital was sponsored by the Price–Taylor County Medical Society with funds from the Wisconsin Heart Association. Examining physicians at the clinic were *Dr. Warren K. Simmons,* Rhinelander, and *Dr. D. J. Freeman,* Wausau.

Examining patients at the heart clinic held May 20 at the Medford Clinic in Medford were two Madison doctors, *Dr. William H. Ylitalo,* pediatrician, and Dr. Robert J. Corliss, cardiologist. *Dr. W. W. Meyer,* Medford, is area heart chairman.

Physicians whose names appear in italics are members of the State Medical Society.

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MEDICINE IN ART

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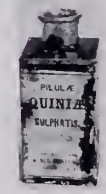

HISTORICAL ARTIFACTS

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"History is not only that which is hundreds of years old. History is today's events. They should be recorded for the time when they can be evaluated in the light of experience and impartiality."

THANKS

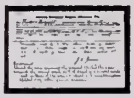
MRS. FRED A. TUCKER, Oak Park, Ill., for the century-old silver cup which once belonged to her grandfather, Dr. John B. Dousman, one of the makers of Milwaukee's medical history.

The cup, which is engraved with the words, "John B. Dousman, M.D., Christmas 1863," is one of several items donated by Mrs. Tucker, who was born Margaret Dousman. Doctor Dousman was a younger brother to Col. Hercules Dousman, builder of the Villa Louis at Prairie du Chien. He was born at Mackinac Island July 30, 1807, and received his early education at the classical college of the Rev. Dr. Rudd at Elizabethtown, N. J. After six years there he began the study of medicine under Dr. Amos Twitchell, a prominent practitioner of Keene, N. H., and then attended medical lectures alternately at Boston and New York. In 1826 Doctor Dousman entered practice with his preceptor, Doctor Twitchell. He came to Wisconsin in 1840 and after practicing for two years in the village of Waukesha he settled in Milwaukee, which at that time had an estimated population of 2,500 and a total of nine physicians. One of the city's leading doctors, he assisted in the organization of The Medical Society of Milwaukee County and at one time served as president of the State Medical Society of Wisconsin. His death occurred Feb. 4, 1868.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS



MEDICAL MUSEUM

COUNTY PROCEEDINGS *continued*

RACINE

The summer dinner dance of the Racine County Medical Society took place June 15 at Meadowbrook Town and Country Club.

The society's meeting on May 27 in Racine featured a talk by *Dr. William P. Crowley, Jr.*, Madison, on the topic, "Disability Evaluation—Consultative Fees."

RICHLAND

Dr. George Benson of the Veterans Administration Hospital in Madison was speaker for the Richland County Medical Society meeting May 4 in Richland Center. His subject was physical medicine in clinics and small hospitals.

WALWORTH

Walworth County Medical Society held its last meeting until mid-September on May 20 in Fontana. The 27 who attended included wives and two guests. Speaker was H. L. Burdick, Lake Geneva attorney, who discussed taxes at death. Subjects of discussion during the business session were school immunization, standard insurance company forms, and the fee schedule for Walworth County Public Welfare.

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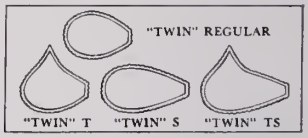

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Wisconsin Heart Association Meets

Dr. Hugh J. McLane, Fond du Lac internist, was chosen as president-elect of the Wisconsin Heart Association at the organization's 17th annual meeting May 15 in Milwaukee. He will take office next May.

James T. Harrington, Milwaukee attorney, was installed as president of the association succeeding *Dr. William B. Hildebrand* of Menasha. Robert A. Sanderson, Whitefish Bay, was reelected secretary-treasurer. New board members include *Drs. John H. Huston* and *Derward Lepley, Jr.*, Milwaukee; *Dr. J. B. Grace*, Green Bay, and *Dr. R. M. Senty*, Sheboygan, elected to three-year terms; and *Dr. Thomas C. Puchner*, Milwaukee, elected to a one-year term.

Some 75 physicians and 150 nurses attending the meeting and scientific sessions heard a luncheon address by Dr. Albert H. Schwichtenberg, head of the department of aerospace medicine and bioastronautics of the Lovelace Foundation at Albuquerque, N. M. Earlier, physicians attending scientific discussions were told that a hospital in Salt Lake City is using computers experimentally to diagnose congenital heart diseases and that their accuracy is greater than that of physicians. Dr. Homer R. Warner, director of the cardiovascular laboratory at the Latter Day Saints Hospital, Salt Lake City, said his hospital had been engaged in computer experiments for five years.

Another speaker, Dr. William T. Mustard, chief of cardiovascular surgery at the Hospital for Sick Children, Toronto, Ont., told of advances in the treatment of congenital heart disease in infants and children.

Northern Chapter, WPA

At the April 3 meeting of Northern Chapter, Wisconsin Psychiatric Association, at Wisconsin Dells, *Dr. C. F. Midelfort* of La Crosse presented a paper in which he enunciated the idea that religious affinities of man are inherent as a means of overcoming fear and promoting self-mastery.

Among the participants on a panel which was next on the program was *Dr. Milton H. Miller* of Madison. Program chairman was *Dr. J. B. Lefsrud* of La Crosse. Chapter president-elect, *Dr. Charles A. Wunsch*, Green Bay, convened the gathering of psychiatrists and clergymen.

Milwaukee County Medical Assistants

Dr. Miles B. Smith, Milwaukee, was the featured speaker at the April 22 meeting of the Milwaukee County Medical Assistants Society. His topic for the evening meeting was the St. Mary's Burn Center.

Ozaukee–Sheboygan County MAS

A mental magic performance by *Dr. Robert S. Pavlic* of Brookfield was a feature of the Ozaukee–Sheboygan County Medical Assistants Society annual "Bosses Night" dinner May 25 at Sheboygan.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

The society president, Mrs. Eleanor Schaut, welcomed the assemblage and presented honorary memberships to *Dr. Edward E. Houfek*, Sheboygan, and *Dr. A. H. Barr*, Port Washington. Another speaker was Mrs. Aleen Piepenburg of Waukesha, president of the Wisconsin State Medical Assistants Society.

Toastmaster was *Dr. David J. Batzner*, Sheboygan. Among those introduced were Miss Alice Roelse, Port Washington, president-elect of the state organization; Mrs. June Gillette, past state and local president, who served as dinner chairman; Mrs. Luella Hoffmann, president-elect; Mrs. Gladys Olson, treasurer; and three advisers, *Drs.* Batzner, *Paul P. Bassewitz*, and *Robert M. Senty*, Sheboygan.

Door County MHA

The team approach to mental health was discussed at a seminar sponsored by the Door County Mental Health Association May 16 in Sturgeon Bay for physicians, nurses, and clergymen. The meeting was also open to Kewaunee County people.

Appearing on the program were *Dr. Leigh M. Roberts*, Madison, assistant professor of psychiatry at the University of Wisconsin Medical School, and a panel whose members included *Dr. Patricia F. Lanier* of Kewaunee.

State Society of Pathologists

The mid-year (summer) meeting of the Wisconsin Society of Pathologists was held June 12 at State Medical Society headquarters in Madison. Opening remarks were made by Society president, *Dr. Robert S. Haukohl*, Milwaukee. Speakers at the morning session were Dr. Julia Backus, St. Luke's Hospital, Milwaukee, "Chromosomal Technique and Analyses," and *Dr. Robert Scheidt*, also of St. Luke's, Milwaukee, "An Automated Analysis of Amylase." *Drs. Robert D. Neubecker* and *Charles I. Bowerman*, St. Joseph's Hospital, Marshfield, moderated a tissue seminar on gynecologic and obstetric pathology which began in the morning and continued following luncheon. The evening was devoted to dinner and a business meeting.

WHA, Racine Woman's Auxiliary

The Wisconsin Heart Association and the Woman's Auxiliary to the Racine County Medical Society sponsored a seminar for Racine physicians and clergymen May 19 in Racine. One of the keynote speakers was Dr. Edgar Draper, psychiatrist and ordained minister from the University of Chi-

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cago. The Rev. James R. Love, retired chaplain, also spoke. Moderator for the seminar was *Dr. Richard J. Mayer*, president of the Racine County Medical Society. An evening session for wives of clergy, physicians, and dentists, and attorneys featured Doctor Draper and the Reverend Love in a discussion moderated by Karl H. York, administrator for St. Luke's Hospital, Racine.

Medical Alumni Association

Dr. James W. Nellen, Green Bay, new University regent, was the principal speaker for the meeting of the Wisconsin Medical Alumni Association May 4 at the Coach House Motor Inn, Milwaukee. The gathering took place in conjunction with the State Medical Society meeting. Program chairman was *Dr. Silas Evans* of Milwaukee.

Wisconsin Chapter, NMSS

Dr. T. L. Vogel, Janesville, and *Dr. Francis M. Forster* and *Dr. H. H. Reese*, Madison, are trustees of the Wisconsin Chapter of the National Multiple Sclerosis Society, which opened its 1965 campaign in May. Doctor Forster is also chairman of the medical advisory committee. The state chapter serves about 10,000 patients afflicted with multiple sclerosis and, through the national society, also engages in research aimed at cause and cure of the disease.

Ashland District, WNA

Approximately 100 members of the medical, dental, and nursing professions of the Ashland and Superior Districts enjoyed the annual spring dinner meeting sponsored by Ashland District of the Wisconsin Nurses Association May 20 in Ashland. Guest speaker was Dr. James Segraves, Chicago, nationally known authority on the subject of disaster planning.

Sheboygan County Unit, WHA

"The Cardiac in Industry" was the subject of the second annual conference of the Wisconsin Heart Association's Sheboygan County Unit June 3 in Sheboygan. A panel of experts in the field of cardiology conducted the program. Members included *Dr. Donald M. Rowe*, Kohler Clinic, who spoke on "Heart Disease Detection in Industry," and *Dr. Thomas C. Puchner*, Milwaukee cardiologist, whose subject was "Can Heart Disease Be Prevented?".

Milwaukee Gynecological Society

Dr. M. Alex Krembs was elected president of the Milwaukee Gynecological Society at the group's annual business meeting on May 10 at the University Club of Milwaukee. *Dr. William P. Wendt* was chosen as vice-president. The Society's secretary-treasurer is *Dr. Saul F. Schwartz*, who was elected in 1964 to a two-year term. *Dr. J. A. Klieger* is the immediate past president.

Winnebago County Unit, ACS

Winnebago County Unit of the American Cancer Society sponsored two talks by *Dr. Sanford Mackman* of Madison May 20 at Winneconne. Doctor Mackman addressed Winneconne High School students in the afternoon and the Winneconne Parent-Teacher Association in the evening. He is an instructor in the Division of Clinical Oncology and Department of Surgery at the University of Wisconsin Medical School. There will be a cure for cancer within this decade, he said, but to get the job done the United States will have to increase the $150 million it is spending annually on cancer research.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Carlson at St. Mary's

Dr. David J. Carlson, former associate director of Milwaukee Hospital's Department of Laboratories, Clinical and Anatomic Pathology, on July 1 assumed his new duties as director of laboratories at St. Mary's Hospital, Milwaukee.

Dr. Miller Attends Course

Dr. Thomas Miller, Wausau orthopedic surgeon, attended a course in lower extremity prosthesis-amputation at Northwestern University Medical School for a week in May.

Dr. Curreri Receives Appointment

Dr. A. R. Curreri of the Department of Clinical Oncology, University of Wisconsin Medical School, Madison, has been appointed by Stephen Ailes, Secretary of the Army, to serve for two years on the Army Scientific Advisory Panel. The panel, composed of 25 scientists, educators, engineers, and industrialists, advises on all scientific and related matters of concern to the Army.

President's Reception

PRESENT AND PAST: Greeting guests at the President's Reception on May 23 at State Medical Society headquarters in Madison were (left to right) Dr. and Mrs. J. H. Haughtan, Wisconsin Dells, and Dr. and Mrs. W. P. Curran, Antigo. Doctor Houghtan is president and Doctar Curran immediate past president of the Society. About 350 attended the afternoon affair.

Dr. Eickhoff at AAGP Assembly

Dr. E. C. Eickhoff, Land o' Lakes physician and surgeon, attended the Annual Scientific Assembly of the American Academy of General Practice in April at San Francisco. Doctor Eickhoff is a member of the Academy.

Dr. Church Retiring as Health Director

Dr. Ruth E. Church, Waukesha County health director since the department was formed in 1961, announced early in May that she will retire Jan. 1, 1967. She intends to do consulting work in Waukesha after retirement, Doctor Church said.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Pearce to Kentucky

Dr. L. W. Pearce, medical director of the Walworth County Counseling Center at Elkhorn from September 1963 until June 30 of this year, will begin work August 1 in his new position as medical director of the Louisville, Ky., Mental Health Center. He will be engaged in supervising psychiatric residents and he is to be appointed to the faculty of the University of Louisville's School of Medicine. *Dr. C. O. Chicks,* Janesville, will serve as a replacement on a one-day-a-week basis until a fulltime medical director is found.

Dr. Cartes Takes Over Office

Dr. Alfredo Cartes took over the practice of the late Dr. Bruno Warschauer April 22 in Milwaukee. A 1954 graduate of Asuncion University in Paraguay, Doctor Cartes interned at St. Joseph's Hospital, Atlanta, Ga., and had practiced at Western State Hospital, Staunton, Va., before locating in Milwaukee in 1963. He is a native of Paraguay.

Dr. McKenna Feted on Birthday

Hundreds of cards from well wishers throughout the Antigo area were showered on *Dr. E. A. McKenna* May 5 in observance of his 65th birthday. Doctor McKenna has been a physician in Antigo from the time of his graduation in 1929 from Northwestern University Medical School until his recent retirement. One of his eight children is following in his footsteps. He is *Dr. John E. McKenna,* who is practicing in Antigo. A daughter, Patricia, is a nurse at Langlade County Memorial Hospital.

Dr. Nuland Certified

Dr. S. J. Nuland, Platteville surgeon since 1962, was notified late in April that he had been certified by the American Board of Surgery.

Gundersen Foundation Program

Gundersen Clinic personnel representing nine areas of practice presented talks and demonstrations at the first medical science program the Adolf Gundersen Medical Foundation has held in approximately 10 years. Among those appearing on the April 28 program at La Crosse Lutheran Hospital were *Drs. A. G. Brailey, Jr., John E. Reinert, Robert Green, George B. Murphy, Jr., D. G. Tompkins, R. W. Ramlow, S. C. Copps, Rolv Slungaard, P. J. Helliesen, Bernard Kalfayan,* and A. Erik Gundersen.

PHYSICIAN NEWS *continued*

Dr. DeCock Replaces Dr. Benton

Dr. R. D. DeCock has been appointed to the Appleton Board of Health succeeding *Dr. J. L. Benton*, who declined reappointment after serving more than 35 years. *Dr. C. D. Neidhold* was recently reappointed to the board. Appleton health commissioner is *Dr. J. W. Laird.*

Dr. Leitschuh Diplomate

Dr. T. H. Leitschuh, Veterans Administration Hospital, Wood, has been named a diplomate in psychiatry of the American Board of Neurology and Psychiatry.

Dr. Pawsat Reappointed

Dr. E. H. Pawsat, Fond du Lac, has been reappointed a member of the Council on Voluntary Health Agencies of the American Medical Association.

Middleton Library Groundbreaking

Photo courtesy WISCONSIN STATE JOURNAL

AS SMILING COLLEAGUES WATCHED, *Dr. William S. Middleton*, emeritus dean of the University of Wisconsin Medical School, turned the first shovelful of dirt at the groundbreaking ceremony for the Middleton Medical Library honoring him. The groundbreaking was the opening event of the 10th annual Alumni Weekend of the Medical Alumni Association. *Dr. Peter L. Eichman*, new Medical School dean, at the left in the background, led the group attending the ceremony. Miss Helen Crawford, medical librarian, is directly behind Doctor Middleton. The library will be constructed at the Medical Center on Linden Drive. About $800,000 of the $1.1 million available for its construction came from medical alumni, other donors, and earnings on investments.

Dr. Currier Promoted

Dr. George Currier has been named assistant director of mental health for Milwaukee County. Doctor Currier came to Milwaukee in 1960 and for his first year there served as director of the Psychiatric Clinic at Milwaukee County Mental Health Center. In 1961 he was named clinical director of North Division, a position he held until his promotion on March 29. He is an assistant professor of psychiatry, adjunct, in the Department of Psychiatry, Marquette University School of Medicine, and has been active in the senior medical student program as well as in the Milwaukee County psychiatric residency program.

Drs. Lewis, Ousley on Committee

Dr. R. F. Lewis and *Dr. J. L. Ousley*, together with Floyd Detert, administrator, comprised the building committee directing the half-million-dollar Marshfield Clinic building expansion program recently completed in Marshfield. By October 1, Mr. Detert said, nine more doctors will be added to the Clinic staff, which by late April had reached a total of 57. Accommodations are designed for an eventual staff of 75 physicians.

Clinic Completion Expected

A new medical clinic begun last year in Elkhorn was expected to be ready about July 1 for occupancy by *Drs. H. R. Mol* and *R. J. Rogers.*

Dr. Ravn Honored

Dr. Erling O. Ravn, Sr., was honored for his 50 years of service in the medical profession on May 12 when fellow staff members and special guests gave him a dinner at Holy Cross Hospital, Merrill. *Dr. W. E. Braun*, chief of staff at Holy Cross, was host for the event attended by medical and dental staff members, including those from Wausau and Medford. *Dr. W. P. Curran*, Antigo, immediate past president of the State Medical Society, was among the guests.

Tributes were paid to Doctor Ravn and his accomplishments as a leader in his profession and the community were recounted. Doctor Ravn has practiced in Merrill since 1919, when he joined his father, Dr. Michael Ravn, in practice. In 1924, the two were joined by his brother, Dr. Bjarne Ravn. Still active, Doctor Ravn is now in practice with his son, *Dr. Erling O. Ravn, Jr.*, who was one of the physicians attending the dinner.

Dr. Amberg to San Francisco

Dr. John Amberg, director of radiology at Milwaukee County General Hospital since 1957 and chairman of the radiology department at Marquette University School of Medicine since 1960, has resigned to join the radiology department of the University of California Medical Center in San Francisco. He will become chief of radiology service at

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the Veterans Administration Hospital in San Francisco, which has a relationship with the university medical center similar to that of Milwaukee County and Marquette University.

Dr. Schmidt Named Health Officer

Dr. E. M. Schmidt has been appointed to a two-year term as Berlin city health officer succeeding *Dr. Grant C. Stone.*

Dr. Tobin at Meeting in Ireland

Dr. J. M. Tobin, director of the Northwest Psychiatric Clinic Research Center in Eau Claire, was one of eight American participants at the International Conference on Schizophrenia held May 28 through 31 at a castle near Shannon, Ireland. Doctor Tobin presented a paper entitled "Probability Theory in the Biological Origins of Schizophrenia."

Dr. Jensen Blue Cross Director

Dr. F. G. Jensen, Menasha, has been elected to the board of directors of the Wisconsin Blue Cross Plan. He fills a place on the board left vacant by the February death of Dr. George E. Forkin of Menasha.

Dr. Mudge Promoted

Dr. W. A. Mudge, Jr., Kenosha internist and cardiologist who is also a member of the faculty at Marquette University School of Medicine, has been promoted to the rank of assistant clinical professor. The promotion was effective July 1.

CANCER CYTOLOGY COURSE OFFERED BY U.W.

A 12-month course in cancer cytology will be offered next fall by the University of Wisconsin Medical School, it was announced by Dr. Alfred S. Evans, chairman of the department of preventive medicine.

Students accepted for the course will receive $225 monthly stipends from the U. S. Public Health Service.

Doctor Evans said the training will enable graduates to work in medical clinics, hospitals or public health laboratories throughout the country. There is a great current demand for cytotechnicians, he said.

Students who have completed two years of college and have at least 12 credits in biology may apply. Those who complete the course are certified by the Registry of Medical Technologists as qualified cytotechnicians.

Applications are available from the University of Wisconsin Medical School. Completed applications and transcripts of grades should be sent to Dr. William D. Stovall, School of Cancer Cytology, Department of Preventive Medicine, University of Wisconsin, Madison, Wis. 53706.

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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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PHYSICIANS SPEAK AROUND THE STATE

Dr. H. B. Wagner, assistant pathologist at St. Catherine's Hospital, Kenosha, explained the role of the pathologist to St. Catherine's Hospital Auxiliary members at a meeting May 20 in the hospital auditorium.

Dr. Patricia F. Lanier, Kewaunee physician, was featured speaker May 18 at a meeting of Ripon Branch of the Association of American University Women.

Dr. R. J. Samp, Madison, spoke on the topic, "Fads, Fats and Fancies," at the annual spring luncheon of the Whitefish Bay Woman's Club. Doctor Samp also spoke before an audience of 200 persons May 5 during the third annual Mental Health Week dinner in Fond du Lac, and at the Fox River Valley Alumni Association of the University of Wisconsin Founders Day dinner April 29 in Appleton.

Dr. R. A. Pribek, staff member at the La Crosse Clinic, represented La Crosse County Chapter of the Wisconsin Heart Association when he spoke May 10 before a meeting of the South Side Businessmen's Association in La Crosse.

Dr. W. H. Heywood, Marshfield psychiatrist, discussed the developmental phases of crisis and the influence crisis has upon the individual's personality development at the third all-clergy conference April 29 in Stevens Point.

Dr. Gerald C. Gant, University Hospitals, Madison, outlined the requirements and training of a physician at a meeting of the Webb High School Scientiae Medicae Club April 22 in Reedsburg.

Dr. James D. Whiffen, Madison, assistant professor of surgery, University of Wisconsin Medical School, addressed the La Crosse District Nurses Association May 5 at St. Francis Hospital, La Crosse.

A panel of four Green Bay physicians, *Drs. J. E. Dettmann, T. J. Beno, J. K. Theisen*, and *J. F. Mokrohisky*, answered questions from about 65 journalism students from 18 Brown County high schools May 12 at a question and answer program on the relationship between smoking and cancer sponsored by Green Bay Chapter of the American Cancer Society.

Dr. J. L. Weygandt, Sheboygan Falls health officer, spoke on "Medical Aspects of Traffic Safety" at the May 10 meeting of the Sheboygan Falls Kiwanis Club.

Dr. James H. Rupple, Fond du Lac ophthalmologist, gave a talk illustrated with colored slides as guest speaker for a meeting of the Fond du Lac Faculty Wives on May 11 in Fond du Lac.

Dr. R. B. Larsen of the Wausau Clinic discussed medicare at a meeting of the Breakfast Optimist Club May 10 in Wausau.

continued next column

PHYSICIAN NEWS *continued*

Dr. Youmans Named to Office

Dr. William B. Youmans, Madison, was elected a regional vice-president of the Oregon Medical School Alumni Association during the group's annual scientific meeting this spring.

Dr. Schaefer Shows Film

Dr. F. L. Schaefer, Menasha gynecologist and obstetrician, presented the film, "Self Examination of the Breast," to the Rosary Society of St. John's Catholic Church April 22 at Menasha.

Dr. Wilkinson Honored on Birthday

Dr. J. F. Wilkinson, who has been practicing medicine in Oconomowoc since 1922 when he became associated with his father, the late Dr. M. R. Wilkinson, was honored by physicians and staff of the Wilkinson Clinic April 10 at a surprise party celebrating his 70th birthday.

Reminiscing about earlier days on that occasion, Doctor Wilkinson recalled the old sprinkling wagon which held down the dust in summer, and the wooden sidewalks fashioned according to the owner's desire. In a comment which points up the difference in character between that day and the present, he said "If you stumbled over a loose board you did not contemplate a law suit against the owner but politely put the board back in place hoping the owner did not see you and suspect you of damaging his property."

Two of Doctor Wilkinson's brothers, *Dr. John* and *Dr. Donald Wilkinson*, joined the Clinic in 1929.

Tribute Paid Dr. Jackson

A new general surgery section in the North American Federation of the International College of Surgeons will annually honor the memory of the

PHYSICIANS SPEAK continued

Dr. J. N. Bonner, Appleton, explained fields open to graduates of nursing schools at a joint meeting of the Future Nurses Clubs of Kimberly and St. John High Schools, Little Chute, May 3 at the Kimberly School.

Dr. J. W. Manier spoke on the intern program at St. Joseph's Hospital, Marshfield, and introduced a panel of interns and externs at the hospital, at the May 3 meeting of the Marshfield Rotary Club. Doctor Manier heads the hospital's intern committee.

Dr. H. F. DeMorest, Jr., discussed the "Dangerous Age" at a meeting of the Neenah-Menasha Breakfast Optimist Club on May 11.

As speaker at the annual meeting of the Kenosha County Anti-Tuberculosis and Health Association, *Dr. Clarence W. Jordahl* of Muirdale Sanatorium, Milwaukee, said that tuberculosis must be found before it can be attacked.

late Dr. Arnold S. Jackson of Madison. The first memorial luncheon to be named for Doctor Jackson was held April 28 at Las Vegas, Nev.

Dr. Johnson Helps with Booklet

Dr. Frank K. Johnson, chairman of the pediatrics department and chief of staff at Beloit Hospital, assisted a group of Beloit Junior Woman's Club members (Mmes. John Brewer, Gino Casucci, and Richard Elliott) in their project of writing a booklet for the child facing hospitalization. Doctor Johnson wrote the foreword for the 16-page booklet called "Operation Timothy," and also aided the writers with its content.

Dr. Jahn on NTA Program

Dr. Richard P. Jahn, Milwaukee, medical director for the Wisconsin Anti-Tuberculosis Association, reported on Wisconsin's Operation KO-TB at the annual meeting of the National Tuberculosis Association May 30-June 2 in Chicago.

Dr. Weeks at Harvard

Dr. James H. Weeks, pediatrician at The Monroe Clinic, was one of 55 physicians from 24 states and Canada who took an intensive five-day postdoctoral course in contemporary pediatrics in May at Harvard Medical School. A 1956 graduate of George Washington University School of Medicine, Washington, D. C., he came to The Monroe Clinic in July of 1963.

Dr. Eggman Joins Group

Dr. Lynn D. Eggman joined the staff of the Warner S. Bump Medical Group in Rhinelander July 1. He is a 1962 graduate of the University of Wisconsin Medical School at Madison where he also took his internship and residency in pediatrics.

Dr. Milano at Chicago Tutorial

Dr. Angelo Milano, co-director of laboratories at St. Michael's Hospital, Stevens Point, was one of a dozen pathologists from hospitals all over the United States who attended tutorials on pretransfusion tests and immune reactions to blood transfusions in May at Mount Sinai Hospital Medical Center, Chicago.

Dr. Hatleberg Honored

Dr. C. B. Hatleberg, Chippewa Falls, the man responsible for the Chippewa County Blood Bank, was honored May 27 by team captains from throughout Chippewa County at the 10th anniversary banquet. Tracing the beginnings of the blood bank, Doctor Hatleberg recounted how he contacted the War Memorial Blood Bank, which provided the county with a skeleton plan "which has grown into this successful donor club." Doctor Hatleberg is a former president of the bank, which is now headed by *Dr. L. W. Picotte* of Chippewa Falls.

Dental Society Award

IN RECOGNITION of the cooperative efforts of the Wisconsin State Dental Society in the activities of the Charitable, Educational and Scientific Foundation, a plaque was presented by the Foundation to Dr. T. E. Ryan, Waukesha (left, above), president of the Dental Society, at its annual banquet May 11 in Milwaukee. *Dr. J. H. Houghton,* Wisconsin Dells, president of the State Medical Society, made the presentation. The plaque is shown at the right.

24 Receive Scholarships and Awards at UW Medical School Field Day

Scholarships and awards totalling more than $6,500 were presented to 23 outstanding students and one faculty member of the University of Wisconsin Medical School at the annual Medical School Field Day. *Dean Peter L. Eichman* made the presentations at the May 13 event.

Dr. Richard Wasserburger, associate professor of medicine, received the Medical Alumni Association's $1,000 Award for Distinguished Teaching.

Senior students receiving awards and scholarships were Norman Jensen, Siren, William J. Bleckwenn, Jr., Memorial Award for Clinical Promise ($50 and a parchment certificate); David L. Camenga, Madison, $500 Borden Undergraduate Research Award for meritorious research in medicine; Don Lee Bradke, Madison, $500 Dorothy and Charles Inbusch Award for meritorious research in medicine; John R. Olson, Madison, the $200 Drs. Joseph Dean Award for academic achievement; John N. Drye,

Madison, the $330 Edwin L. and M. Etta Rasey Memorial Scholarship sponsored by the Wisconsin Farm Bureau Federation; John T. Harrington, Jr., Madison, Cora M. and Edward J. Van Liere Award of $165 to the senior with the highest scholastic achievement during medical school; Larry Malewiski, Sheboygan, Sheard–Sanford Award of $100 and a medal for initiative and success in pathology research.

The University of Wisconsin Foundation Awards of $300 each, given annually by an anonymous donor to worthy medical students on the basis of academic ability and need, went to Thomas C. Cesario, senior student from Kenosha; Stephen W. Zimmerman, Madison, and William O. Thomas, Mt. Horeb. Gift certificates for four books, given by Lange Publications for outstanding scholarship, went to seniors, David Boyd, Wauwatosa, and William B. Davies, Waukesha.

The $1,000 Pfizer Laboratories Medical scholarship, based on scholarship and need, went to Judith A. Wynnemer, sophomore from Waseca, Minn. The Lewis E. and Edith Phillips Awards of $500 each were presented to Richard A. Ellingstad, Hudson; Thomas Winch, Waupaca, and David B. Knutsen, Madison, in recognition of superior scholastic ability. William C. Summers received the Theobald Smith Award of $100 and a medallion. Theodore B. Berndt, Wausau, was given a scroll and an Omega watch for the Roche Award, given annually to a junior student who best exemplifies the ideals of the modern physician. The Mosby Award for outstanding scholarship went to five sophomores: David Pfaffenbach, Watertown; Philip Guzelian, Milwaukee; Howard Gutgesell, Brookfield; Sheldon Solochek and Dennis Maki, Madison. Each was given a $30 check for the purchase of books.

Memorial to Dr. Aageson

At an organization meeting held May 24 in Oconto, members of the Oconto Community Betterment Association voted in favor of "Aageson Memorial Lake" as the name for the proposed artificial lake in Oconto. A suitable plaque will be placed at the lake front as a further memorial to the late Dr. H. A. Aageson. The site for the lake was changed from Memorial Park to Holtwood Park.

Kerr-Mills Benefits in Wisconsin Total $2.8 Million First Six Months

The State Department of Public Welfare announced recently that $2,813,500 was spent during the first six months of the Kerr-Mills program in Wisconsin. These benefits, which covered the period ending December 31, were paid by Continental Casualty Co., Chicago, to 7,257 persons. In all, 38,500 claims were processed. Payments included $451,987 to physicians and surgeons; $2,129,147 to hospitals, $89,300 to nursing homes, $125,913 to registered drugstores, $1,315 to dentists, and $15,-838 to visiting nurse associations. Of the amount paid physicians and surgeons, $210,-000 was for surgical care, according to Continental.

Dr. Reider Named to Board of Health

Wisconsin State Health Officer, *Dr. E. H. Jorris*, announced in June that Dr. R. Frank Reider has taken up the duties of director of the Section on Preventable Diseases of the State Board of Health.

Doctor Reider received his B.Sc., M.D., C.M., and D.P.H. degrees from McGill University, Montreal, Canada. A diplomate of the American Board of Preventive Medicine, he entered private practice in New York City in the mid-30s and in 1938 joined the U. S. Public Health Service, which he has served in various capacities. Until he joined the State Board of Health on June 1, he was chief, Training Branch, Division of Health Mobilization.

Drs. Foley, McKelvey Receive Awards

Awards for superior performance were presented to Drs. Charles F. Foley and M. A. McKelvey of the Tomah Veterans Administration Hospital staff on April 21 by Dr. H. E. Wilkinson, hospital director.

Dr. Capelli Certified

Dr. Paul A. Capelli, Kenosha, has been certified as a diplomate of the American Board of Obstetrics and Gynecology.

Medical Alumni Weekend

A groundbreaking ceremony for the new Middleton Medical Library, addresses by several distinguished doctors, class reunions, election of officers, and a banquet were all on the agenda for the University of Wisconsin Medical Alumni Association's 10th annual Alumni Weekend May 20 and 21 in Madison.

Festivities began the afternoon of May 20 with the groundbreaking ceremony for the new library which will be constructed at the Medical Center on Linden Drive. That evening, the Medical School classes of 1955, 1945, 1940, 1935, and 1930 held reunions at restaurants and clubs in Madison and Middleton. About 400 Medical School graduates and their wives attended.

A "State of the Union" message by the Medical School's new dean, *Dr. Peter L. Eichman*, was a feature of the program on May 21. *Dr. Vincent L. Gott*, associate professor of surgery, spoke on "The Status of the Wisconsin Heart Valve" and *Dr. Richard Wasserburger*, associate professor of medicine, delivered the Address by the Recipient of the Distinguished Teaching Award. *Dr. H. Kent Tenney, Jr.*, clinical professor emeritus of pediatrics, gave a talk on "The Many Faces of Medicine" and Dr. Robin C. Buerki gave the Address by the Recipient of the Medical Alumni Citation.

"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.

Doctor Buerki received the Citation at the Medical Alumni Day banquet the evening of the 21st, when Doctor Tenney was presented the association's Emeritus Faculty Award. He is the sixth person to receive the award, and Doctor Buerki is the sixth recipient of the Medical Alumni Citation, which he received "for his outstanding contributions to medical education and for his leadership in advancing the progress of health." A former head of University Hospitals, he retired in January as executive director of Henry Ford Hospital, Detroit. He is now serving on the hospital's board of trustees. A member of the Wisconsin medical class of 1917, Doctor Buerki was one of the driving forces behind the planning, organization, and opening of Wisconsin General Hospital. He was superintendent of that hospital from 1923 to 1941, and also of Children's Hospital from 1931 to 1941. During that time he also served as professor of hospital administration and executive secretary of the Medical School.

Doctor Tenney served on the Medical School faculty from 1920 to 1962, and still continues to teach a few hours a week for the Pediatrics Department. Listeners are familiar with his "March of Medicine" radio program. His notable career has included serving as chairman of the Governor's Committee for Children and Youth, state chairman of the American Board of Pediatrics, president of the State Medical Society, chairman of the Wisconsin Mental Health Advisory Committee, and delegate to the White House Conference on Children and Youth.

During the election of officers May 21, *Dr. Herbert W. Pohle* was elected president of the association succeeding *Dr. Frank L. Weston*. He is chairman of the medicine department at Columbia Hospital, Milwaukee, and Doctor Weston is clinical professor of medicine at the University of Wisconsin Medical School. *Dr. D. J. Freeman*, Wausau, was chosen as president-elect and Doctor Wasserburger was reelected secretary-treasurer.

Dr. Joseph R. Stone, Milwaukee orthopedic surgeon, is the only new member elected to the association's board of directors. Reelected to the board were *Dr. Robert F. Schilling*, Madison, chairman of the Department of Medicine at the Medical School; *Dr. Silas M. Evans*, Milwaukee, clinical professor of medicine at Marquette University School of Medicine, and *Dr. Herbert Giller*, Milwaukee ophthalmologist.

DR. GUNNAR GUNDERSEN

Today's Nursing Home is Different

Dr. Gunnar Gundersen of La Crosse, former president of the Wisconsin State Board of Health and the American Medical Association, told some 75 delegates to the spring conference of the Wisconsin Association of Nursing Homes at the Eau Claire Hotel May 24 that the primary function of a nursing home is to prepare patients to return to their own homes and families. Doctor Gundersen spoke at a dinner meeting on the first day of the two-day conference.

He said that rather than an institution for custodial care, the nursing home should be a place where the aged and chronically ill patient may receive the medical care he needs. Doctor Gundersen said the nursing home no longer is a "glorified boarding house" but rather an institution that eventually discharges patients to return to their homes.

Today's nursing home, he said, must provide a positive program for each patient since it is the last stop in an extended care program. The demand for nursing home care will grow, Doctor Gundersen declared, since the demand for medical service generally will be "tremendously increased" in a few years. He said the home is not necessarily for the aged patient and that the belief that patients come to nursing homes to "waste away" must be replaced with a philosophy that a nursing home is a place in which patients become well.

Doctor Gundersen said the nursing home fills the needs of the long-term patient who cannot afford extended hospital care and that the solution to the problem of extended medical care is in the hands of nursing home operators.

He said that home with only room and board and limited medical care cannot meet today's needs and that the nursing home must take an "enlightened medical and psychological approach" and treat the patient as an individual capable of an interest in life and not as a "worthless has-been."

Doctor Gundersen emphasized the fact that older persons want acceptance by others and not pity or sympathy and that attention to such persons' emotional and psychological needs gives them "a new lease on life."

The problems of the older patient require more attention but that they still must have rehabilitative therapy and realistic goals, he said. He added that the primary objective of a nursing home is to provide an environment where health treatment is adequate.

Doctor Gundersen said he believed the owner managed home to be the best since the owner has the full responsibility of operation. He said the American Medical Association accreditation program, now in its third year, is designed to aid and encourage homes to come up to high standards and that an accredited institution is one in which it is known quality care is provided.

The conference, with nearly 200 at the final session, ended May 27 following a panel discussion on responsibilities of nursing home administrators.

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OBITUARIES

Dr. George E. Forkin, 84, prominent Menasha physician whose practice dated back to horse and buggy days, died Feb. 13, 1965. He was born in Chilton and was a graduate of the University of Illinois, where he received his M.D. in 1905.

A physician for 60 years, Doctor Forkin was a champion of the general practitioner, and his many accomplishments included serving as second president of the Wisconsin Academy of General Practice. He was also a member and past president of the Winnebago County Medical Society, a life member of the State Medical Society of Wisconsin, which he had served in 1952 and 1953 as speaker of the House of Delegates, a member of and alternate delegate to the American Medical Association, and a member since 1955 of the board of directors of Associated Hospital Service, Inc., the Wisconsin Blue Cross Plan. At the time of his death he was serving on its finance committee.

Doctor Forkin practiced for a year in Highland and for three years in Hilbert before locating in Menasha in 1909. He delivered between 4,000 and 5,000 babies during his years there, and vividly recalled his experiences during the terrible flu epidemic of 1918.

For four years Doctor Forkin had served as chief of staff of Theda Clark Memorial Hospital, Neenah.

He is survived by a son and daughter, Edward W. Forkin of Green Bay and Mrs. Gertrude Powell of Deerfield, Ill. Another daughter, Miss Katherine Forkin, died Feb. 25, 1965.

Dr. Gilbert F. Fitzgerald, 67, died Feb. 15, 1965, in Milwaukee, his native city.

A 1923 graduate of Marquette University School of Medicine, Doctor Fitzgerald practiced in Milwaukee from 1923 to 1944, and had been on the staff of Milwaukee County Hospital, Johnston Municipal Hospital, and Misericordia Hospital. He was an associate member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and numerous Milwaukee organizations.

In World War I, he served as a second lieutenant in the U.S. Army Infantry.

Surviving is Doctor Fitzgerald's widow, Maude.

Dr. Nordahl O. Gunderson, 77, native of Stoughton, died unexpectedly Feb. 21, 1965, at his home in Madison. He had retired to that city in 1959 after serving for 38 years as part-time and, later, full-time health officer at Rockford, Ill. Since 1961 he had been a consultant for the Winnebago County, Ill., Health Department in Rockford.

Doctor Gunderson was a 1916 graduate of Northwestern University School of Medicine. He was a member of the American Medical Association, Illinois State Medical Society, Winnebago County, Ill., Medical Society, and the American Public Health Association.

He is survived by his widow, Irene.

Dr. Josef Seilin, retired Antigo physician, died Feb. 22, 1965, at the age of 77.

Born in Siberia, Doctor Seilin came to this country with his parents in 1893, locating at Chicago. There he received his medical degree from the University of Illinois College of Medicine in 1915, and the year following served his internship at Lakeview Hospital. He practiced in Chicago from 1916 until 1946, when he became a staff member of the Veterans Administration, serving in various localities until 1958. From 1959 until his retirement last year, he had practiced at Antigo.

Doctor Seilin was a member of the Langlade County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow and three daughters: Mrs. Herbert Danoff, Studio City, Calif.; Mrs. Brett Kramer, Oxford, England; and Phoebe, a student at the University of Wisconsin, Madison.

Dr. William C. Liefert, who retired in 1959 after 27 years as a doctor at the Veterans Administration Center at Wood, died Mar. 4, 1965, at his home in Shorewood. He was 79.

Milwaukee born, Doctor Liefert received his medical education in that city, graduating from Marquette University School of Medicine in 1909. His internship and residency were served at Milwaukee County General Hospital. In World War I, Doctor Liefert was a medical officer in the 32nd Division. He was in private practice in Milwaukee until 1932, when he went to the Veterans Administration. From 1947 until his retirement he was medical chief of outpatient service there.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and its Fifty Year Club, the American Medical Association, the Milwaukee Neuropsychiatric Society, and the Association of Military Surgeons of the United States.

Surviving is a nephew, Dr. Karl Liefert of Milwaukee.

Dr. Delos F. Doyle, 52, La Crosse physician since 1942, died Mar. 7, 1965, in Madison.

Doctor Doyle, who was born in Cuba City, received his M.D. in 1941 from Marquette University School of Medicine, Milwaukee, and interned at St. Francis Hospital, La Crosse. After practicing for a year at Highland, he became associated with Dr. E. E. Gallagher (now deceased), Dr. F. J. Gallagher, and Dr. John J. Simones in La Crosse. He was on the staff of St. Francis and La Crosse Hospitals.

Doctor Doyle was a member and past vice-president of the La Crosse County Medical Society, the State Medical Society of Wisconsin, which he had served as secretary for the 7th Councilor District, the American Medical Association, and the American Academy of General Practice.

Surviving are his widow, Mary; four sons, Patrick and James, La Crosse; Ray, with the U.S. Navy in Viet Nam, and Michael, at home; six daughters, Mary Lynn, Madison; Mrs. LaVerne Grimslid, Milwaukee; and Anne, Kathy, Peggy, and Susan, all at home.

Dr. William A. Joseph, a native of Sparta, died Mar. 19, 1965, at the age of 81. He was a resident of Hales Corners.

A general practitioner and proctologist, he was a 1912 graduate of Marquette University School of Medicine and had practiced in the Milwaukee area since 1919, with the exception of the years 1945 to 1952, when he was located in Mississippi. He was on the staff at St. Luke's Hospital, Milwaukee.

Doctor Joseph was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Among his survivors are his widow, Bessie, and two daughters, Mrs. Enid Franklin and Mrs. Bessie Raffler.

Dr. Homer Dexter Ludden, 85, retired Mineral Point physician and surgeon, died Mar. 19, 1965, at Dodgeville. He leaves two daughters, Mrs. Harry Ivey, Mineral Point, and Miss Margaret Ludden, Chicago; a brother, J. B. Ludden, Cross Plains; and two grandchildren, Mineral Point.

Doctor Ludden was a native of Chicago and received his M.D. degree there in 1905 from Rush Medical College, the University of Chicago. After interning at St. Mary's Hospital, Milwaukee, he began his life's work as a general practitioner in 1906 at Mineral Point, where he became a community leader as well as a leader in medical circles. He tried to retire in 1947 but many of his old patients refused to accept that retirement and it was not until 1955 that he retired completely.

During his years of active practice, Doctor Ludden served three terms as chief of staff at St. Joseph's Hospital, Dodgeville, where, later on, he was honored when the hospital renamed its medical library the "Dr. Ludden Memorial Library." For many years he was a trustee of the Iowa County Hospital and Home, and after his retirement he was active in raising funds for a new, modern building for that institution. He was a member of the Iowa County Medical Society, which he had served as secretary, treasurer, and president, held an honorary life membership in the State Medical Society of Wisconsin, and was a member of the American Medical Association.

During World War I, he was engaged in active duty as a battalion surgeon in the Medical Corps.

One of his happiest and proudest recollections was of the moving tribute paid him in 1954 when, as a grateful acknowledgment of his many years of dedicated service, the citizens of Mineral Point set aside a whole day as "Dr. Ludden Day." Another proud day was when he was given a 50-year pin by the State Medical Society.

During his last illness, while he was confined to St. Joseph's Hospital, Doctor Ludden was honored by the Wisconsin Academy of General Practice by being named as one of the first two recipients of a newly established citation to "aged, retired or disabled doctors, who have been a credit to their profession and a service to their community."

Dr. Carl Wright Lockhart, a life member since 1949 of the State Medical Society and a life member and past president of the Ashland-Bayfield-Iron County Medical Society, died in Ashland Mar. 29, 1965, at the age of 90. He was also a 50 Year Club member of the State Society.

Doctor Lockhart had been a member of the State Medical Society continuously since 1902, and in addition to his membership in that, his county society, and the American Medical Association, he was also a member of the Railway Surgical Society. He was as active in civic affairs as in medical, and in 1952, the Lions Club of Mellen honored him as "outstanding citizen of the year."

Born in 1875 in Utica, Doctor Lockhart received his medical degree in 1901 from the College of Physicians and Surgeons of the University of Illinois, Chicago, and interned at Chicago Hospital. He had conducted an active practice at Mellen for a half century prior to his retirement.

Among his survivors are two sons and a daughter, Thomas Andrew, Ontonagon, Mich., and John Mallory, Cincinnati, O., and Dr. Lucy McMurray, Albuquerque, N. M.

Dr. Maurice J. Reuter, Sr., 65, Milwaukee dermatologist, died Apr. 5, 1965. He was a native of Dexter, Mo.

In addition to his private practice, Doctor Reuter was an assistant clinical professor of dermatology at Marquette University School of Medicine, Milwaukee, where he received his medical degree in 1924. From 1923 to 1925 he interned at Milwaukee County Hospital and New York Lying-In Hospital, and from 1927 to 1930 he served a residency at the Mayo Clinic, Rochester, Minn.

He was certified by the American Board of Dermatology and Syphilology and held membership in the American Dermatological Association, American Academy of Dermatology and Syphilology, the Chicago Dermatological Society, the Wisconsin Dermatological Society, the Minnesota Dermatological Society, the Milwaukee Academy of Medicine, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Among his survivors are his widow, Jeannette; and four children, Dr. Maurice J., Jr., and Mrs. Raymond Lauerman, Milwaukee; James J., Corte Madera, Calif., and Thomas F., Chicago.

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Dr. Ben Lue Fabric, 55, former Milwaukee physician, died at his home in Hallandale, Fla., Apr. 7, 1965.

Milwaukee born, he was a graduate of Marquette University School of Medicine and served his internship at Milwaukee County General Hospital. He practiced in Milwaukee until 1950, when he moved to Miami. He was a member of the American Medical Association and since 1960 he had been a member of the Dade County Medical Society and Florida State Medical Society. Prior to that date he held membership in The Medical Society of Milwaukee County and State Medical Society of Wisconsin.

Survivors include his widow, Mollie, and four sons, Stuart, Bruce, and Elliot, Hallandale, and Robert, Coral Gables, Fla.

Dr. Bruno Warschauer, longtime Shorewood physician, died Apr. 7, 1965, in Milwaukee. He was 68.

He was born in Breslau, Germany, where he received his medical education at the University of Breslau, winning his M.D. degree in 1923. He interned at Wentzel Hanoke Hospital and Jewish Hospital, Breslau, in 1923 and 1924, and served a residency at Shorewood Hospital and Riverside Sanitarium, Milwaukee, from September 1924 to January 1927. He was naturalized in 1930. He was a veteran of service in the German Army in World War I.

Doctor Warschauer was a member of the American Academy of General Practice, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, the American Medical Association, and fellow of the American Geriatrics Society.

Survivors include his widow, Myra; a daughter, Mrs. John Franklin, Detroit, and a son, Thomas, in the U.S. Navy, stationed at Virginia Beach, Va.

Dr. Edmund H. Mensing, retired Milwaukee physician and surgeon who last year became a life member of the State Medical Society, died at the age of 78 on Apr. 10, 1965, in Milwaukee. He had been a member of the State Society's 50 Year Club since 1959.

A native of Milwaukee, Doctor Mensing was a 1909 graduate of Northwestern University Medical School, Evanston, Ill. He served an internship at Michael Reese Hospital, Chicago, and a fellowship at the Mayo Clinic, Rochester, Minn. Before his retirement he had been an attending surgeon at Deaconess Hospital and a consulting surgeon at St. Michael's Hospital, Milwaukee, and a surgical consultant at the Veterans Administration Hospital at Wood. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

In World War I, Doctor Mensing saw active service in the A.E.F. from March 1918 to July 1919.

Surviving are his widow, Katherine, and two daughters, Mrs. David Kranbuehl and Mrs. Ralph Teitgen, Milwaukee.

Dr. John P. Canavan, Neenah, a physician for 48 years and first president of the Wisconsin Academy of General Practice, died Apr. 13, 1965, at the age of 78. He had practiced in Neenah for 39 years before retiring last June.

The grandson of pioneer Outagamie County residents, he was born in Roberts County, South Dakota, in 1887 but when his mother died a month later, the family returned to Outagamie County, where the boy lived with an uncle, Dr. James V. Canavan. He received his medical degree in 1916 from Marquette University School of Medicine, Milwaukee, and practiced at Winneconne until 1925 when he located in Neenah.

Doctor Canavan was a former president of the staff of Theda Clark Memorial Hospital in Neenah and for many years was physician and surgeon for the Neenah Eagles. He was a member of the American Academy of General Practice and one of the founders, as well as first president, of the Wisconsin Academy of General Practice, which received its charter in 1948. He and the late Dr. George E. Forkin of Menasha were honored in 1950 for their leadership in founding the organization. In 1952, the first issue of *The Wisconsin Family Physician*, an Academy publication, was dedicated to Doctor Canavan.

He was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, and he was also very active civically. A memorial in his name has been established at Theda Clark Hospital.

The only survivor is a son, John, Green Bay.

Dr. Constantine M. Wahl, semi-retired Spring Green physician, died at Madison Apr. 25, 1965, at the age of 86. More than 40 years of his over a half century in medical practice had been spent in Spring Green.

Born in Cross Plains, he was a graduate of Valparaiso University Medical School in Indiana and of Loyola College Medical School. He was a former assistant surgeon to the late Dr. Reginald Jackson in Madison, and health officer for Troy and Spring Green townships and the villages of Spring Green and Lone Rock.

Survivors include his widow, Erma; two sons, Milton, Madison, and Russell, Spring Green, and a daughter, Mrs. Roy Kroemer, Madison.

* * *

A STUDY HAS shown there are over 45 scientists per 10,000 employees in the drug industry, highest ratio in any industry. In the chemical industry, there are 13 scientists per 10,000 employees; six in the petroleum industry, and four in the electrical industry.

MEMBERSHIP REPORT AS OF JUNE 8, 1965

SOCIETY RECORDS

NEW MEMBERS

Alan B. Adam, 9035 Watertown Plank Rd., Milwaukee.
Robert G. Aug, 8700 W. Wisconsin Ave., Milwaukee.
Alvin L. Berman (Ph. D., Associate Professor of Anatomy), University of Wisconsin, Madison 53706.
Russell C. Briggs, 1300 University Ave., Madison.
Albert R. Bryan, 103 W. College Ave., Appleton.
David Gordon Bryant, 503 Rosa Rd., Madison.
Edward J. Buerger, 3066 N. 52nd St., Milwaukee.
John A. Chopyak, 2212 W. State St., Milwaukee.
Alfonso Deiparine, Jr., 2709 S. 102nd St., West Allis.
Mario M. DeOliveira, 425 E. Wisconsin Ave., Milwaukee.
Thomas J. Flatley, 2040 W. Wisconsin Ave., Milwaukee.
Louis J. Floch, 5625 Washington Ave., Racine.
James E. Forsyth, Winnebago State Hospital, Winnebago.
Paul H. Goldstein, 2040 W. Wisconsin Ave., Milwaukee.
John E. Gorrell, 2900 W. Oklahoma Ave., Milwaukee.
Walter G. Gunn, 8700 W. Wisconsin Ave., Milwaukee.
David W. Kersting, 561 N. 15th St., Milwaukee.
Paul J. Lawrence, Union Grove.
Kenneth O. Loken, 925 Mound St., Madison.
Peter L. McDermott, 3127 W. Fardale, Milwaukee.
Roger C. Mercado, 6233—8th Ave., Kenosha.
Jules O. Meyer, 3880 N. Richards St., Milwaukee.
William A. Morgan, 1836 South Ave., La Crosse.
Kenneth G. Newby, 59 Racine St., Menasha.
Edwin O. Niver, 605 Walker Ave., Eau Claire 54701.
Paul J. Pitlyk, 2266 N. Prospect Ave., Milwaukee.
Charles J. Pophal, 2471 N. 41st St., Milwaukee.
Raymond J. Rogers, Oconto.
T. A. Schimanek, 3815 Monona Dr., Apt. 35, Madison 53714.
Samuel J. Skemp, 312 State St., La Crosse.
Salvatore A. Spicuzza, 1436 E. Lake St., Hopkins, Minn.
Thomas T. Tang, 1700 W. Wisconsin Ave., Milwaukee.
David T. Uehling, 1300 University Ave., Madison.
Jose A. Villacrez, The Monroe Clinic, Monroe.
Richard L. Wesenberg, 21 Sherman Ter., Madison 53704.
Anthony P. Ziebert, 525 Elm Spring St., Milwaukee.

REINSTATED

Charles S. Baker, 500 W. Milwaukee St., Janesville.
Vaughn Demergian, 30 S. Henry St., Madison.

CHANGES OF ADDRESS

H. W. Aufderhaar, 211 Memorial Dr., Fort Atkinson 53538.
David J. Baker, 417 Milwaukee Ave., Burlington.
Rudolph Balzer, Oak Creek, to 2625 W. Greenfield, Milwaukee 53215.
Richard E. Bilbo, Milwaukee, to 1310 Victoria Cir., Elm Grove.
Albert J. Blair, Madison, to Karolinska, Sjukhuset, Stockholm 60, Sweden.
D. C. Bleil, 2500 N. 108 St., Milwaukee 53226.
R. O. Brunkhorst, 4222 W. Capitol Dr., Milwaukee.
John T. Bruton, 807—16th St., Racine.
Donald R. Burke, 2405 Northwestern Ave., Racine.
Alfredo Cartes, 3954 N. Oakland Ave., Milwaukee.
Hermann A. Denzel, Winnebago, to Psychiatr, Landeskrankenhaus, Weinsberg, 7102, Germany.
John C. Docter, Racine, to Plum City 54761.
Edwin F. Dorzeski, 811—5th Ave., Antigo.
C. C. Edmondson, 717 N. East Ave., Waukesha 53186.
A. C. Edwards, 720 Ash St., Baraboo 53913.
Stanley M. Englander, 2405 Northwestern Ave., Racine.
Frank J. Erdlitz, Mauston, to Necedah.
John H. Esser, 1050 W. Acacia Rd., Milwaukee 53217.
Calvin Gillespie, 10940 West Forest Home, Milwaukee.
George N. Gillett, 5625 Washington Ave., Racine.
Peter B. Golden, 206 S. Whitney Way, Madison 5.
Herbert W. Granzeau, 320 N. Pine St., Burlington.
Frank A. Gruesen, 315 Hillcrest Ave., Fort Atkinson.
Bahri O. Gungor, Loyal, to Neillsville.
John H. Hogan, 1511 Park Ave., Racine 53403.
James H. Holman, 500 Walton Ave., Racine 53402.
H. N. Hunsader, 411 Madison Ave., Fort Atkinson 53538.
Joseph C. Kiser, Madison, to Apt. 898B, Homestead Village Lane S.E., Rochester, Minn.
Curtis C. Knight, 725 W. Washington Ave., Madison.
H. C. Koch, 151 N. Wisconsin, Berlin 54923.
J. C. Koch, 209 E. Park Ave., Berlin 54923.
D. E. Koepke, Madison, to 324 E. Wisconsin Ave., Milwaukee 53202.
George Krismer, 325 E. Jefferson St., Burlington.
Russell M. Kurten, 3905 N. Bay Dr., Racine.
S. J. Leibenson, 1433 Hazel St., Oshkosh 54901.
A. M. Lindner, 429 Main St., Racine.
Robert F. Lipo, New Berlin, to 5367 Eastway, Greendale 53129.
Ernest L. Mac Vicar, Jr., Franksville, to 500 Walton Ave., Racine.
Marcial E. Martinez, 1526 Grand Ave., Racine.
M. Martinez-Larre, 610 Sixth St., Racine.
Laird McNeel, 325 E. Jefferson St., Burlington.
Paul L. Miller, 1320 Wisconsin Ave., Racine.
C. E. Oberdorfer, 1320 S. Wisconsin Ave., Racine.
Ernest S. Olson, 1320 S. Wisconsin Ave., Racine.
Russell H. Owen, 4333 Nakoma Rd., Madison 53711.
Robert L. Pettera, P. O. Box 301, Tacoma, Wash. 98401.
Daniel J. Price, 7551 N. Fairchild, Milwaukee.
Martin A. Rammer, Jr., Fort Rueker Ala., to 1720 N. 8th St., Sheboygan.
John Rankin, 6026 Greentree Rd., Madison 53711.
Robert N. Richards, 1601 S. Erickson Ave., Marshfield.
Eugene R. Rightmyer, Box 1406, Milwaukee 53201.
L. L. Sanford, LaFarge, to Hillsboro.
Roland J. Schact, 1632 Douglas Ave., Racine.
E. M. Schmidt, P. O. Box 48, Berlin 54923.
Harold T. Schroeder, 834 S. Main St., Racine
Cleon L. Schultz, 2201 Barnett Dr., Roswell, N. M. 88201.
Myron Schuster, 1526 Grand Ave., Racine.
Alois J. Sebesta, P. O. Box 311, Shawano.
William H. Snook, Fox Lake, to 401 N. Center St., Beaver Dam 53916.
Robert A. Songe, Wausau, to 24601 Fairmount, Dearborn, Mich. 48124.
Robert A. Stanley, 220—7th Avenue W., Ashland.
C. L. Steidinger, 1370 N. Water St., Platteville.
J. B. Tweeten, 821 Wilson Ave., Menomonie 54751.
R. E. Urbanek, 1200 N. Center St., Beaver Dam.

SOCIETY RECORDS *continued*

M. J. Valaske, San Diego, Calif. to U. S. Naval Hospital, Great Lakes, Ill. 60088.
Dale Van Wormer, Madison, to Hillcrest Medical Center, Tulsa, Okla. 74104.
Joseph J. Voytek, Route #3, Fort Atkinson 53538.
George E. Whalen, Brookfield, to 3477 N. Lake Dr., Milwaukee.
George W. Wirtanen, 201 Richland Lane, Madison 5.
Robert C. Wolf, 5513 S. 110 St., Hales Corners 53130.
Loren J. Yount, New Berlin, to 2320 N. Lake Dr., Milwaukee.

REMOVED FROM MEMBERSHIP

Merrill P. Benoit, Milwaukee County, transferred to Michigan.
Alfons Busza, Milwaukee County, resigned.
Harold G. Cooper, Outagamie County, removed per county secretary.
William J. Duxbury, Dodge County, removed per county secretary.
Roger B. Goodfriend, Marinette–Florence County, removed per county secretary.
Clinton K. Higgins, La Crosse County, removed per county secretary.
Warren J. Holtey, Wood County, removed per county secretary.
Richard A. Lende, Dane County, removed per county secretary.
Joseph G. Pellicer, Calumet County, resigned.
Raymond H. Quade, Winnebago County, removed per county secretary.
Francis J. Thornton, Milwaukee County, resigned.

DEATHS

Carl W. Lockhart, Ashland–Bayfield–Iron County, March 29, 1965.
Maurice J. Reuter, Sr., Milwaukee County, April 5, 1965.
Bruno Warschauer, Milwaukee County, April 7, 1965.
Edmund H. Mensing, Milwaukee County, April 10, 1965.
John Patrick Canavan, Winnebago County, April 13, 1965.
Constantine M. Wahl, non-member, April 25, 1965.
Ernest O. Ronneburger, non-member, May 8, 1965.
Leander P. Stamm, Milwaukee County, May 8, 1965.
Ralph G. Bonfiglio, Winnebago County, May 11, 1965.
Phillip D. Christensen, Brown County, May 11, 1965.
Maurice Olsen, Milwaukee County, May 15, 1965.
Marshall P. Stamm, Milwaukee County, May 20, 1965.
Stephen E. Sebastian, non-member, May 23, 1965.
Henry O. McMahon, Milwaukee County, May 31, 1965.

* * *

PHARMACEUTICAL industry research spending on medical products is almost nine times more than it was in 1950, increasing from $39 million in 1950 to $346 million in 1965.

* * *

PUBLIC TREASURIES in the U. S. increased their spending for health and medical services from $513 million in 1929 to nearly $9.0 billion in 1965.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
Clinical Psychologist

Phone 567–5535
MILWAUKEE OFFICE—BRoadway 3–6622

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1965 **Wisconsin**

July 22–24: Clinical chemistry conference, Bardeen Auditorium and State Laboratory of Hygiene Auditorium, Madison.

Aug. 23–28: Seminar on control procedures in drug production, Wisconsin Center, Madison.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Sept. 15: Wisconsin State Medical Golf Association, annual fall tournament, Janesville Country Club.

Sept. 25: 11th Annual Fall Cancer Conference, University of Wisconsin Medical Center, Madison.

Oct. 13–14: Postgraduate course, "Clinical Application of Current Concepts in Renal Pathophysiology," University of Wisconsin, Madison.

Oct. 15–16: Council of Wisconsin Society of Internal Medicine, 1965 annual meeting, to be held jointly with regional meeting of American College of Physicians, Wisconsin Center, Madison.

Oct. 29–30: Symposium on "Integration of Social Science Concepts in Psychotherapy," co-sponsored by Milwaukee Sanitarium Foundation and Department of Psychiatry, Marquette University School of Medicine, Coach House Motor Inn, Milwaukee.

Nov. 4–5: Symposium on epilepsy, auspices of Department of Neurology, University of Wisconsin Medical School, Wisconsin Center, Madison.

Nov. 12–14: Wisconsin Society of Pathologists, annual meeting, held jointly with North Central Region of College of American Pathologists, Wisconsin Society of Medical Technologists and Wisconsin Radiological Society, Marquette University, Mamie's Grotto, and Coach House Motor Inn, Milwaukee.

1965 **Out-of-State**

July 26–30: Continuation course on cardiac arrhythmias, Hahnemann Medical College and Hospital, Philadelphia.

July 29: 2nd International Congress of Psychosomatic Medicine in Obstetrics and Gynecology, Vienna, Austria.

Aug. 2–6: Department of Pediatrics and Office of Postgraduate Medical Education of University of Colorado School of Medicine, 8th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 4–15: American Physicians Fellowship, orthopedic seminar, under jurisdiction of Israel Medical Association, in Israel.

Aug. 8: 8th International Anatomical Congress, Wiesbaden, Germany.

Aug. 9–13: University of Colorado School of Medicine, post-graduate course in internal medicine, Estes Park, Colo.

Aug. 16–20: University of Colorado School of Medicine, medical audiology workshop, Estes Park, Colo.

Aug. 19–20: Fourth annual postgraduate conference on medical aspects of sports, sponsored by University of Rhode Island and Rhode Island Medical Society, Keaney Gymnasium of University of Rhode Island, Kingston, R. I.

Aug. 22–27: Flying Physicians Association, 11th annual meeting, Deauville Hotel, Miami Beach, Fla.

Aug. 22–27: American Academy of Physical Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30-Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15, 1965–June 15, 1966: Tutorial program in cardiology offered by Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16: Seventh International Congress of General Practice, Salzburg, Austria.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Sept. 20–Oct. 2: Postgraduate course in laryngology and bronchoesophagology conducted by Department of Otolaryngology of University of Illinois College of Medicine, Illinois Eye and Ear Infirmary, Chicago.

Sept. 21–23: University of Minnesota Department of Pediatrics, continuation course in pediatrics, University of Minnesota campus, Minneapolis.

Sept. 23–25: 11th International Congress of Radiology, Rome, Italy.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 11–13: Academy of Psychosomatic Medicine, annual meeting, Sherman House, Chicago. Joint morning meeting and luncheon Oct. 11 with American Society of Clinical Hypnosis.

Oct. 11–13: University of Colorado School of Medicine, postgraduate course, "The Hospital Medical Staff," Estes Park, Colo.

Oct. 13: Department of Psychiatry and Neurology, Chicago Medical School, start of postgraduate courses in psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists.

Oct. 13–14: American Heart Association Council on Arteriosclerosis, annual meeting, Hotel Deauville, Bal Harbour, Fla.

Oct. 14–16: University of Colorado School of Medicine, postgraduate course, "Medical Education in the Hospital," Estes Park, Colo.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Oct. 18–22: American College of Chest Physicians, postgraduate course No. 1, "Clinical Application of Cardiopulmonary Physiology," Knickerbocker Hotel, Chicago, Ill.

Oct. 23–28: American Academy of Pediatrics, 34th annual meeting, Palmer House, Chicago.

Oct. 28–30: American College of Gastroenterology, annual course in postgraduate gastroenterology, Americana Hotel, Bal Harbour, Fla.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30–Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–4: Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

Nov. 5: International College of Surgeons, divisional meeting, Urbana, Ill.

Nov. 8–12: Course in occupational health for registered nurses in industry, offered by Department of Environmental Medicine of New York University Medical Center in cooperation with American Association of Industrial Nurses, New York University Medical Center.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI meeting, Pick–Congress Hotel, Chicago, Ill.

Nov. 15–18: Interstate Postgraduate Medical Association Scientific Assembly, Cleveland, O.

Nov. 15–19: American College of Chest Physicians, postgraduate course No. 2, "Diagnosis and Treatment of Diseases of Heart and Lungs," Barbizon Plaza Hotel, New York City.

Nov. 19–22: National Society for Crippled Children and Adults, annual convention, Palmer House, Chicago, Ill.

Nov. 22–24: 15th Hahnemann Symposium, "Cancer Chemotherapy: Basic and Clinical Applications," sponsored by Department of Medicine, Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia 2, Pa.

Dec. 8–10: Hahnemann Symposium, "New Concepts in Gynecological Oncology," Sheraton Hotel, Philadelphia 2, Pa.

1966

Jan. 20–22: World congress on diabetes in tropics, under auspices of Diabetic Association of India, Bombay, India.

Jan. 24–28: American College of Chest Physicians, postgraduate course No. 3, "What's New in Diagnosis and Treatment of Cardiovascular and Pulmonary Diseases," Fontainebleau Hotel, Miami Beach, Fla.

Feb. 6–13: Canadian-American Medical Dental Ski Association, sixth annual meeting, The Lodge At Vail, Colo.

Feb. 14–18: American College of Chest Physicians, postgraduate course No. 4, "Clinical Application of Cardiopulmonary Physiology," Ambassador Hotel, Los Angeles, Calif.

March: Five-day course of instruction in otolaryngologic allergy, sponsored by The University of Tennessee College of Medicine, Memphis.

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 11–13: American College of Chest Physicians, postgraduate course in "Cine-Angiographic Techniques in Cardiovascular Diseases," Cleveland Clinic, Cleveland, O. Tuition, ACCP members, $60; nonmembers, $75.

Apr. 20–23: 16th Hahnemann symposium, "Arterial Occlusive Disease," postgraduate education course sponsored by Hahnemann Medical College and Hospital, Marriott Motor Hotel, Philadelphia, Pa.

June 26–July 2: 7th International Congress of Gerontology, Imperial Castle, Vienna, Austria.

Aug. 20–25: 9th International Congress on Diseases of Chest, sponsored by Council on International Affairs of American College of Chest Physicians, H. C. Orsted Institute, University of Copenhagen, Copenhagen, Denmark.

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Oct. 16–20: Interstate Postgraduate Medical Association Scientific Assembly, Washington, D.C.

Clinical Chemistry Conference

A clinical chemistry conference sponsored by the Clinical Chemistry Departments of University Hospitals and the State Laboratory of Hygiene will be held July 22 through 24 in Madison. The July 22 session of registration and lectures will be held at Bardeen Auditorium (the north wing of the Hospital). Sessions July 23 and 24 will be held at the State Laboratory of Hygiene Auditorium.

The program will open July 22 at 9 a.m. with a talk by F. J. Wenzel, director of laboratories, Marshfield Clinic, Marshfield, on "Instrumentation for the Measurement of Acid Base Balance." At 10:30 a.m., Dr. J. A. Glennon, Department of Medicine, University Hospitals, Madison, will speak on "Some Application of PH Measurements in Body Fluids." Speakers in the afternoon will be Dr. J. J. Lalich, Department of Pathology, University Hospitals, "Lipids and Their Relation to Atherosclerosis," 1:30 p.m., and Dr. J. M. B. Bloodworth, Jr., Veterans Administration Hospital, Madison, "Diabetes Mellitus," 3 p.m.

Dr. Gerald Cooper, chief of the Medical Laboratory Section, Communicable Disease Center, Atlanta, Ga., will open the program July 23 at 9 a.m., with a paper on "Clinical Determination of Enzymes." A second paper will be presented by Theodore Gerritsen, D.Sc., Department of Pediatrics, University Hospitals, on the subject, "Methodology for the Determination of PKU."

Following lunch, Dr. J. L. Sims, Department of Medicine, University Hospitals, will speak on "Serum Protein Patterns and Liver Disease," followed by Dr. H. A. Peters, Department of Neurology, University Hospitals, "Heavy Metals and Their Relation to Porphyrias."

Doctor Cooper will make a second appearance on the program at 9 a.m. July 24 with a paper on "Quality Control."

Course in Renal Pathophysiology

A two-day postgraduate course on "The Clinical Application of Current Concepts in Renal Pathophysiology" will be offered at the University of Wisconsin, Madison, October 13–14. Coordinated by the University Extension, it has been designed to present an organized review and appraisal of current knowledge in several major areas of renal disease and to relate this knowledge to the evaluation and management of clinical renal problems.

Specialists from the University of Wisconsin Medical School staff and from institutions throughout the United States will comprise the faculty. Drs. Arvin B. Weinstein and Richard E. Rieselbach of the Department of Medicine, UW Medical School, are co-chairmen. Guest faculty will include Dr. Lewis W. Bluemle, Jr., University of Pennsylvania Medical School, Philadelphia; Drs. Neal S. Bricker, Herbert Lubowitz, and William T. Newton, Washington University School of Medicine, St. Louis, Mo.; Dr. John H. Dirks, National Heart Institute, Bethesda, Md.; Dr. David P. Earle, Northwestern University School of Medicine, Chicago; Dr. George Gee Jackson, University of Illinois College of Medicine, Chicago; Dr. Edward J. Lennon, Marquette University School of Medicine, Milwaukee; Dr. Victor E. Pollak, Michael Reese Hospital and University of Illinois College of Medicine, Chicago; and Dr. George E. Schreiner, Georgetown University School of Medicine, Washington, D. C.

Additional information may be obtained from Paul Knipping, 403 Extension Building, University of Wisconsin, Madison 53706.

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In painful skeletal muscle spasm, relief of pain does not always follow relaxant therapy, as in the presence of—

Provocative pain, when muscle spasm is triggered by some underlying musculoskeletal defect.

Residual pain, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

Severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

Emotionally aggravated pain, when anxiety or agitation creates tensions that undermine the efficacy of relaxant medication.

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Conference on Medical Aspects of Sports

More than 200 physicians, athletic directors, coaches, and trainers from all parts of the country are expected for the fourth annual postgraduate conference on the medical aspects of sports August 19–20 at the University of Rhode Island Keaney Gymnasium, Kingston, R. I. Leading anatomy and orthopedic specialists, physicians to the U.S. Olympic Team, and nationally known coaches and trainers are on the program for the conference, which is sponsored by the University and the Rhode Island Medical Society.

Continuation Course in Pediatrics

The University of Minnesota Department of Pediatrics announces a continuation course in pediatrics entitled "Genesis, Epigenesis, Modern Physic and the Child," to be held on the University of Minnesota campus September 21–23. The format will be one of illustrative case presentation and didactic transmission leading into small group seminar participation by registrants and staff.

Guest speakers include Drs. John D. Crawford, associate professor of pediatrics, Harvard Medical School, Boston, Mass.; Leo Kanner, professor emeritus of psychiatry, Johns Hopkins Medical School, Baltimore, Md.; Victor Vaughn, professor of pediatrics, St. Christopher's Hospital for Children, Temple University School of Medicine, Philadelphia, Pa., and John P. Conrad, pediatrician and allergist, Fresno, Calif.

Further information may be obtained by contacting Dr. Edward C. Defoe, Department of Pediatrics, University of Minnesota Hospitals, Minneapolis, Minn. 55455.

Pathologists Holding Joint Meeting with State Medical Technologists, Radiologists

The annual meeting of the Wisconsin Society of Pathologists will be held jointly with the North Central Region of the College of American Pathologists, the Wisconsin Association of Medical Technologists, and the Wisconsin Radiological Society on November 12, 13, and 14 in Milwaukee.

The program is as follows:

November 12—Pre-convention petit workshops, Pathology Department, Marquette University School of Medicine 1. Disorders of Coagulation, conducted by Dr. Armand J. Quick, emeritus professor of biochemistry, and Dr. Clara Hussey, instructor in pathology, Marquette University; 2. Instrumentation, conducted by Dr. Robert Scheidt, St. Luke's Hospital, Milwaukee; annual dinner-business meeting, Wisconsin Society of Pathologists, 5:30 p.m., Mamie's Grotto, 625 East Detroit Street.

November 13—Registration, Coach House Motor Inn, 19th and Wisconsin Avenue, 8:30 a.m.; opening remarks, 9 a.m.; scientific papers, presented by combined membership of the Wisconsin Society of Pathologists and Wisconsin Association of Medical Technologists, 9:10 a.m.; luncheon recess, 12 noon; continuation of scientific program for WAMT only: tissue seminar on breast tumors and mammography, Marquette University School of Medicine, moderated by Dr. John W. Berg, associate attending pathologist, Memorial Hospital for Cancer and Allied Diseases, New York, and Dr. Robert L. Egan, associate professor of radiology, Emory University School of Medicine, Atlanta, Ga., 1:30 p.m.; joint banquet, Wisconsin Society of Pathologists and Wisconsin Association of Medical Technologists, Coach House Motor Inn, 6 p.m.

November 14—Continuation of scientific papers, Wisconsin Association of Medical Technologists, Coach House Motor Inn, 9 a.m.

Seminar slide sets are available on a first-come, first-serve basis at ten dollars ($10) per set. All inquiries should be addressed to Dr. David J. LaFond, Secretary, Wisconsin Society of Pathologists, 561 North 15 Street, Milwaukee, Wis. 53233.

Course in Laryngology, Bronchoesophagology

A postgraduate course in laryngology and bronchoesophagology will be conducted from September 20 to October 2 by the Department of Otolaryngology of the University of Illinois College of Medicine at the Medical Center, Chicago. The course, which is limited to 15 physicians, will be held under the direction of Dr. Paul H. Holinger, professor of bronchoesophagology in the Department of Otolaryngology, at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago. Instruction will be provided by means of animal demonstrations, and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants are asked to write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

Course for Industrial Nurses

A full-time course in occupational health for registered professional nurses in industry will be offered November 8–12 by the department of environmental medicine of New York University Medical Center, in cooperation with the American Association of Industrial Nurses. The course is limited to nurses with experience of five years or less in occupational health.

Tuition will be $75. Course #484. Applications should be sent to the Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N. Y. 10016.

Conferences for Medical Staff

Two related postgraduate conferences for the hospital medical staff will be presented by the University of Colorado School of Medicine in October at Estes Park, Colo. The first is the hospital medical staff conference, which has been rescheduled from

November 8–10 to October 11–13. Second is the conference on medical education in the hospital, dates of which have been changed from November 11–13 to October 14–16. Inquiries should be directed to The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Easter Seal Society

"Impact for Tomorrow" is the theme of the 1965 annual convention of the National Society for Crippled Children and Adults (The Easter Seal Society) November 19–22 at the Palmer House, Chicago. Leaders in the rehabilitation field will participate in general sessions, seminars, workshops, and institutes presenting new techniques and methods in the care and treatment of crippled children and adults.

World Congress on Diabetes in Tropics

Under the auspices of the Diabetic Association of India, a world congress on diabetes in the tropics will be held Jan. 20–22, 1966, in Bombay, India. The conference is open to all workers in the field of diabetes whether or not they are members of the Diabetic Association, provided their papers are ac-

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1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
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cepted by the Organizing Committee. Abstracts of papers along with the title of the article and the names of all the authors should reach the Organizing Secretary by October 15, and the full text of the article along with the list of references by Jan. 1, 1966.

Further information may be obtained by writing to the Organizing Secretary, World Congress on Diabetes in the Tropics, care Diabetic Association of India, Maneckji Wadia Bldg., Mahatma Gandhi Road, Bombay 1, India.

1966 WATA Annual Meeting

Apr. 1, 1966, at the Coach House Motor Inn, Milwaukee, have been set as the date and place for the annual meeting of the Wisconsin Anti-Tuberculosis Association, which will be called the 1966 Conference on TB eradication. The day following the conference the Wisconsin Thoracic Society will hold its annual meeting at the Coach House.

UW Postgraduate Program on Surgery

The postgraduate program, "Current Concepts in Surgery," slated for August 26–28 at The Wisconsin Center, Madison, will open at 9:30 a.m., August 26 with registration at the Center, 702 Langdon Street. Luncheon, at noon in the Center's dining room, will be followed at 1 p.m. by a program on the topics, Biliary Surgery, Newer Diagnostic Aspects, Precautions, and Reconstruction; Pyloric Stenosis; Surgical (Endocrine) Physiology; Hepatic Resection; Gastric Surgery; and Abdominal Vascular Accidents. A panel will discuss Surgery of the Biliary System.

"Ongoing Clinical Research Programs at the Wisconsin Medical Center" will be the topic of the evening session which will open at 7:30. Eight presentations of approximately 10 minutes each are scheduled.

Topics August 27 will be a Résumé, Indications and Results of Cardiac Surgery; Prosthetic Valvular Appliances; Esophageal Problems in Infancy and Adults; Thoracic Outlet Syndrome; and Peripheral Vascular Disease. A panel will consider the subject of Blood Coagulation (Surgical Application) including Thromboembolism. The afternoon is unscheduled, and at 6:30 a banquet will be held in the Towers Dormitory.

Topics for consideration at the August 28 program, which will open at the Center at 8:30, include Surgery and the Emphysematous Patient; Distal Alimentary Tract Obstructions in Childhood; Appendiceal Disease; Surgical Implications of the Thymus; Chemotherapy, and Chemotherapeutic Infusions of the Major Viscera; Surgical Physiology, Trauma; Neck Dissections; Obstructive Uropathy in Children; Childhood Chest Deformities; Pain—Thoracic, Abdominal and Extremity.

Guest professors will be Dr. Frank Glenn, New York; Dr. Harold Laufman, Chicago; Dr. George T. Shires, Dallas, Tex.; Dr. Clifford D. Benson, Detroit, Mich., and Dr. Johann L. Ehrenhaft, Iowa City, Ia. Special interests of the five are cardiac surgery, general, and biliary tract surgery (Glenn); surgical aspects of blood coagulation and thromboembolic disease (Laufman); general surgery, endocrinology and surgical physiology (Shires); pediatric surgery (Benson); and cardiac, pulmonary and esophageal surgery (Ehrenhaft).

On the host faculty will be Dr. Robert C. Hickey, program coordinator, and other members of the University of Wisconsin Medical Center staff.

CAMDSA Annual Meeting in Colorado

The Canadian-American Medical Dental Ski Association (CAMDSA) will hold its sixth annual meeting Feb. 6–13, 1966, at The Lodge At Vail, Colo. Secretary-treasurer of the organization is Dr. T. J. Trapasso, 816 Ashmun Street, Sault Ste. Marie, Mich. Travel and Reservations: Group and Travel Inc., 131 East Allegan St., Lansing, Mich. Reservation commitments are expected by September 1.

Symposium on Epilepsy

Under the auspices of the Department of Neurology of the University of Wisconsin Medical School, Dr. Francis M. Forster, Professor and Chairman, a symposium on epilepsy will be held November 4 and 5 at the Wisconsin Center at the University of Wisconsin, Madison. Supported by the United States Public Health Service, Bureau of State Services, the symposium is for state service physicians in the 17-state area extending from Wisconsin to and including Alabama and Florida.

The program will be released at a later date.

Flying Physicians

The 11th annual meeting of the Flying Physicians Association will be held at the Deauville Hotel in Miami Beach August 22 through 27, according to Dr. J. S. Huebner, Fond du Lac, chairman of the association's Wisconsin chapter. The continuing theme for the scientific portion of the program, Doctor Huebner noted, will be the over-riding importance of safety as it relates to general aviation.

The association was established in 1954 to promote general aviation safety. Membership is open to all licensed physicians who are members of medical societies approved by the board of directors. Physicians who are not actually pilots but who have a genuine interest in aviation may hold associate membership in the association. Total current membership now exceeds 1,700 persons. Of these, 31 are practicing physicians in Wisconsin.

Symposium on Suicide

A symposium on suicide, one of the few major scientific meetings ever devoted exclusively to this national health problem, will be conducted by George Washington University School of Medicine October 14 in Lisner Auditorium, Washington, D. C.

The day-long program will explore the many facets of the subject, including suicide's cultural role, social causation, statistical importance, psychodynamics, treatment, and prevention. The audience, invited from a wide geographic area, will include physicians and other individuals with a professional or scholarly concern with suicide.

American Academy of Pediatrics Meeting

Some 3,000 pediatricians are expected to attend the 34th annual meeting of the American Academy of Pediatrics October 23–28 at the Palmer House, Chicago.

The meeting will include general session panels and symposiums on carbohydrate metabolism; teenagers; recent epidemics, including encephalitis and rubella; bases of child development; recent and exciting developments in pediatrics, and antimicrobial agents; several special reports; the annual business meeting, presentation of awards, alumni gatherings, and several clinical conferences at Chicago hospitals.

The Academy meeting is open to physicians who are not pediatricians. Registration fees are $15 for Academy members, applicants to the Academy or the American Board of Pediatrics, nonmembers out of school less than five years, and physicians in the Armed Forces. Registration fee for nonmember physicians out of school more than five years is $50.

Interested physicians may write to the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204, for a preliminary program and housing and registration forms.

Academy of Psychosomatic Medicine

The annual meeting of the Academy of Psychosomatic Medicine will be held at the Sherman House in Chicago October 11–13.

Since these sessions will overlap those of the American Society of Clinical Hypnosis, the two groups will hold a joint morning meeting and luncheon on October 11. Dr. Jules Masserman, professor of psychiatry, Northwestern University School of Medicine, will be the luncheon speaker.

During the Academy's scientific sessions, reports will be presented on psychosomatic problems of children, college students, and the aged. Emphasis will also be placed on digestive and eating disorders, heart disease, and stomach malignancies. Dr. George R. Pollock, director of the Chicago Institute for Psychoanalysis, will deliver the annual Franz Alexander Memorial Lecture on October 12.

About 600 members are expected to attend the meeting. For further information, write Edwin Dunlop, M.D., 150 Emory St., Attleboro, Mass. 02703.

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Chicago Postgraduate Program

To meet the growing need for further training and experience in the areas of psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists, basic and advanced courses will again be offered by the Department of Psychiatry and Neurology of the Chicago Medical School beginning October 13, Dr. H. H. Garner, Department chairman, announces.

Aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy.

Enrollment is limited and advance registration is required. Communications should be addressed to: Bernard Block, M.D., Director—Continuing Education, Department of Psychiatry and Neurology, The Chicago Medical School at Mount Sinai Hospital, 2755 W. 15th St., Chicago, Ill. 60608.

Congress on Diseases of Chest

The Ninth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, will be held in Copenhagen, Denmark, Aug. 20–25, 1966.

The Congress will be presented by the College with the cooperation of the medical societies of Denmark. It will be held in the H. C. Orsted Institute of the University of Copenhagen.

Additional information may be obtained by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

AHA Annual Scientific Sessions

Six programs on clinical cardiology and simultaneous sessions on specialized cardiovascular subjects have been planned for the American Heart Association's 38th annual Scientific Sessions, to be held Oct. 15–17, 1965, at the Hotel Americana, Bal Harbour, Fla.

The Clinical Sessions, consisting of panels, symposia, lectures and papers reporting clinical investigations, are designed as a postgraduate course in cardiology. They are of particular interest to the practicing physician.

Registration forms, which include applications for hotel reservations, may be obtained from local Heart Associations or the AHA national office, 44 East 23rd St., New York, N. Y., 10010.

AHA Arteriosclerosis Council to Meet

The annual meeting of the Council on Arteriosclerosis of the American Heart Association will be held October 13 and 14 at the Hotel Deauville, Bal Harbour, Fla., immediately preceding the Association's annual Scientific Sessions. The Council sessions will be open to all interested individuals. Additional information regarding the Council sessions may be obtained from the American Heart Association, 44 East 23rd Street, New York, N. Y., 10010.

Nursing Care of the Cardiac Patient

Registered nurses and members of allied health professions are invited to attend a national clinical conference on Nursing Care of the Cardiac Patient on Wednesday and Thursday, Oct. 13–14, 1965, in Miami Beach. The meeting, co-sponsored by the American Heart Association's Nursing Committee and the American Nurses' Association Conference Group on Medical-Surgical Nursing, will be held at the Carillon Hotel.

Included for discussion are new aspects of treatment and nursing care of the patient with myocardial infarction; facilities, equipment and nursing responsibilities in coronary care units; and medical management of congestive heart failure, including follow-up measures by the physician, public health nurse and dietitian.

A $10 registration fee will be charged for the Conference, with registration forms available from the American Heart Association, 44 East 23rd Street, New York, N. Y., 10010. Registration at the nursing conference will also admit nurses to the Scientific Sessions of the American Heart Association, to be held October 15–17 at the Hotel Americana, Bal Harbour.

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Inadequate Surgery in the Treatment of Invasive Carcinoma of the Cervix

By A. E. SCHULTZ, M.D., M. J. THORNTON, M.D., E. L. ROLEY, M.D., and B. M. PECKHAM, M.D., Madison, Wisconsin

■ IN THE MANAGEMENT of an active cancer service where nearly 100 per cent of the patients are referred by other physicians and 20 per cent have had treatment prior to admission, one cannot fail to be impressed with the importance of the initial decisions regarding therapy for patients with carcinoma of the cervix. Where complete records are kept and all patients are followed indefinitely after admission and treatment, the results of therapy become clearly apparent, for the vast majority of patients with persistent disease are dead within a period of two to three years after initial treatment.

It is not our purpose here to review current therapeutic procedures and the results of therapy as conducted on this service, but rather to draw attention to a group of patients whose admission each year suggest that there are still physicians in our state not cognizant of the fact that simple hysterectomy with or without removal of the tubes and ovaries is not appropriate therapy for frankly invasive carcinoma of the cervix. It is our hope that by presenting the facts surrounding the management of 39 patients admitted to this service during the seven-year period beginning Jan. 1, 1956, and ending Dec. 31, 1962, we will reduce the prevalence of these patients on our service and more importantly, throughout the state as a whole.

Fortunately, this group constitutes a very small fraction of the patients treated for invasive carcinoma in the state judging from the fact that they constitute only 7 per cent of the patients treated at our hospital for invasive carcinoma of the cervix during the period of this study (Table 1).

In Table 2 these 39 patients are grouped according to their preoperative diagnosis. It is immediately clear that in 22 instances the managing physician was under the misapprehension that simple surgery is adequate therapy for invasive carcinoma of the cervix. The tragedy of this situation is most clearly portrayed by the fact that of the 22 patients in this group for whom simple surgery was deliberately selected when the preoperative diagnosis of invasive cervical

TABLE 1—*Total Admissions, Invasive Carcinoma of the Cervix, Jan. 1, 1956–Dec. 31, 1962*

Untreated	
Invasive (Stages I–IV)	385
Previously treated	
Radiation or radical surgery	122
Simple hysterectomy	39
Total	546

From the Department of Gynecology and Obstetrics, University Hospitals, University of Wisconsin Medical School.

TABLE 2—*Simple Hysterectomy in Cervical Carcinoma*

Preoperative Diagnosis	Postoperative Diagnosis	Number of Patients	Number Living
Invasive carcinoma	Invasive carcinoma	22	5*
In situ or neg. Pap., biopsy or cone	Invasive carcinoma	6	3**
Unsuspected (symptom diagnosis)	Invasive carcinoma	8	2
Abn. Pap. only	Invasive carcinoma	3	1

*Two of these 5 are surviving with persistent carcinoma, 2 years post treatment.
**One of these patients is living following anterior exenteration after radiation failure.

carcinoma was known, only 5 are living and 2 of these are doomed by known persistent disease which cannot be cured.

The misconception that simple hysterectomy is appropriate therapy for such patients may stem from the fact that international Stage I carcinoma of the cervix by definition is "confined" to the cervix. Clearly, "confined" in this instance means clinically or grossly limited to the cervix when this organ is crudely palpated at pelvic examination. It must be remembered that in at least 18 per cent of such patients tumor has already spread to the regional lymph nodes and in even greater number tumor will be found in the immediately adjacent parametrial tissues *which is not clinically detectable.* Obviously, nodal metastases will be unaffected and parametrial tumor will be incised but not removed when simple hysterectomy is the procedure selected.

Therapy of patients with late international Stage O lesions may also be a source of confusion for here there is occasionally a choice between radical surgery and simple surgery. In the management of the average patient with squamous cell carcinoma *in situ,* simple hysterectomy with an adequate vaginal cuff is unquestionably the treatment of choice. Where there is only a suspicion of invasion ("microinvasion") found in an adequate cervical cone specimen, some elect simple hysterectomy on the basis that the disease must still be classified as Stage O carcinoma. However, under no circumstances would this type of therapy, simple hysterectomy, be appropriate where unequivocal stromal invasion is found in either a cone or biopsy specimen.

It is possible that some have confused radical surgery with simple surgery in the treatment of selected cases of invasive carcinoma (International Stage I and early Stage II).

TABLE 3—*Cause of Death after Simple Surgery for Carcinoma of the Cervix*

	No.	No. with Persistent Pelvic Carcinoma
Uremia	4	4
Carcinomatosis	22	21
Hemorrhage	1	1
Pulmonary Embolus	1	1
Total	28	27

That truly radical surgery properly performed can achieve good results in Stage I carcinoma of the cervix is undisputed. Obviously, the procedures used in the management of these patients are a far cry from simple hysterectomy and require an experience in the performance of radical surgery not available to the surgeon who treats an occasional case of invasive cervical carcinoma.

Meigs[1] and Masterson[2] reported a five-year survival of 75 per cent and 80 per cent respectively for their Stage 1 squamous cell carcinoma of the cervix treated by primary radical surgery.

Of the 22 patients in this report electively treated with simple surgery only 5 (23%) are surviving at this writing. This figure will presently fall to less than 14 per cent as 2 have active disease and are only two years post therapy. It is also significant that all of the patients who have died in this series of 39 patients with but one exception have died with active tumor in the pelvis (Table 3).

When adequate *radical* surgery was the therapy used in a series of 100 consecutive patients[2] with Stage I cervical carcinoma, 3 of the 20 patients that died had active disease in the pelvis. This extremely significant difference emphasizes the fact that the line of incision in simple hysterectomy often passes through the tumor and does not encompass it.

Not all of these women suffered simple surgery as the result of a mistake in management. Under the best of conditions, there will be instances where well planned diagnostic procedures fail and the patient with early invasive carcinoma will go unrecognized until after simple surgery has been completed. However, this should indeed be a rare occasion and in our 39 patients accounted for only 6.

In 8 instances the patient was operated upon for some condition other than invasive

TABLE 4—*Survival of Patients With Stage I Carcinoma of the Cervix in Institutions Emphasizing Radiation Therapy*[3, 4]

Name of Institution	5-Year Survival (%)
Radium Hemmet—Stockholm, Sweden	89
Radium Institute of Paris—Paris, France	84
Holt Institute—Manchester, England	69
Roswell Park—Buffalo, New York	72
University of Minnesota—Minneapolis, Minn.	81
Kings County Hospital—Brooklyn, New York	80
University of Wisconsin—Madison, Wisconsin*	83

*Current uncorrected 5-year survival.

The above statistics cannot be directly compared with the 39 patients being reported, as two or three of the 39 were probably more advanced tumors than Stage I.

carcinoma without prior Papanicolaou smear or biopsy. Inadequate treatment of occasional patients is inevitable if the smear is not routinely used prior to hysterectomy for even invasive carcinoma may be asymptomatic. Most of these patients did have abnormal bleeding which was ascribed to other problems (myoma??). Every patient with abnormal bleeding must be considered to have invasive cervical carcinoma until it has been appropriately excluded, for this condition remains a common cause of such bleeding and the commonest type of genital carcinoma at any age.

Three of the 39 patients had known abnormal cytology prior to surgery. It seems likely that this warning went unheeded because the cervix looked and felt deceivingly normal, and it was difficult to conceive that anything more than a surface change could be involved. Just as invasive carcinoma may be asymptomatic, it may also be invisible. *Any abnormal Pap smear is a clear cut indication for cervical biopsy,* a simple office procedure which in most instances will detect the invasive lesion. Though the numbers are small, it seems worthy of note that in the 11 patients comprising the last two groups (Table 2) where surgery was done on the basis of a symptom diagnosis or an abnormal smear without further diagnostic work, the survival (27%) was about as poor as in the group where simple surgery was deliberately selected for management.

The efficacy of *well planned* radiation therapy in the management of early (Stage I) invasive cervical carcinoma is clear when the five-year survival statistics from institutions emphasizing radiation therapy are reviewed (Table 4). As with radical surgery, it is unlikely that the occasional therapist will achieve these results, for experience in recognizing and handling the unusual late Stage I lesions is an important element in achieving this degree of success.

The physician who first sees the patient with invasive carcinoma of the cervix truly holds her fate in his hands, for his decisions relative to therapy will in a large measure determine her destiny, death or survival, though the eventual outcome may not be known for several years.

Summary. Total abdominal hysterectomy with or without salpingo-oophorectomy is inadequate treatment for invasive carcinoma of the cervix. Surgical cure rates in the literature have been achieved by *radical* surgery and cannot be achieved by simple hysterectomy.

THE FIRST PERSON TO TREAT A PATIENT WITH INVASIVE CARCINOMA OF THE CERVIX, BEYOND NECESSARY DIAGNOSTIC WORK, IS GENERALLY THE ONLY PERSON WHO HAS AN OPPORTUNITY TO CURE THE PATIENT.

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Splinting the Acutely Injured Hand

By DONALD M. LEVY, M.D., JACK L. TEASLEY, M.D., and WILLIAM H. FRACKELTON, M.D., Milwaukee, Wisconsin

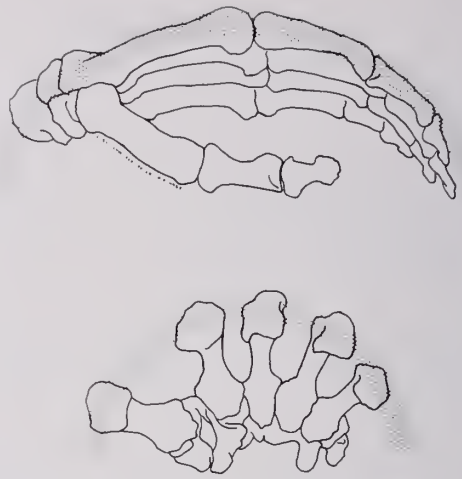

Fig. 1—Natural arches of hand. Top. Longitudinal arch is formed by carpal and metacarpal bones and phalanges. Bottom. Transverse arch is formed by metacarpals as they radiate from their carpal articulation. Convexity of both arches is dorsal.

■ INEFFECTIVE SPLINTING can nullify a well performed operation on an acutely injured hand. Proper splinting depends upon knowledge of certain aspects of the functional anatomy of the hand and of some principles of functional splinting of the hand.

A wonderfully effective and complex structure, the hand consists of more than 260 named parts. It provides the strong grasp of the foundryman shoveling sand, the sensitive touch of the machinist handling a micrometer, and the expressive motions of the gesticulating orator. All of these functions depend upon the integrity of the multiple parts. Since most of these parts move or glide in performance of their functions, fibrosis will reduce their activity profoundly. Alterations in the integrity of skin, the function of nerve, and the freedom of circulation will further compound the disability.

The purpose of splinting the injured hand is to protect it by immobilizing it. Early immobilization of the lacerated, crushed, or burned hand will help control hemorrhage, minimize edema and pain, and prevent further damage from moving sharp fragment of bone. Immobilization of the infected hand limits the spread of the infection. Immobilization of the fractured hand provides the stability necessary for union of the fractures. After repair of nerves or tendons, immobilization protects the surgical juncture against tension and rupture; later a change to dynamic splinting after early healing may aid return of motion.

The carpal and metacarpal bones and the phalanges form two arches—a longitudinal and a transverse (Fig 1). These arches provide positions of function, of power, and of stability; they must be preserved if the normal function of the hand is to be maintained. Because splinting should maintain the integrity of the two natural arches,[1-4] the injured hand, in general, should be immobilized in the *position of function* as illustrated in Figure 2. To achieve this position, the wrist is extended dorsally about 30 degrees, the metacarpal-phalangeal joints are flexed about 45 degrees, the interphalangeal joints are flexed 30 to 45 degrees, and the thumb is placed in abduction and mid-opposition.

Proper splinting of the injured hand is necessary to (1) prevent further injury by motion of the injured parts, (2) lessen edema formation, (3) help control hemorrhage, and (4) reduce pain. The hand should be splinted in the so-called functional position not only as a first-aid measure but also after definitive surgical treatment in most cases. To achieve the functional position, the wrist is extended, the metacarpal-phalangeal and interphalangeal joints are flexed, and the thumb is placed in abduction and mid-opposition. Commercially available splints are useful in the maintenance of this position. The hand should be well padded to prevent compression of nerves and blood vessels and to prevent necrosis of the skin.

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The functional position provides a relative balance between the flexor, extensor, and intrinsic muscles. Extension of the wrist places the extensor and flexor tendons at optimal tension. As shown in Figure 3, the lateral collateral ligaments of the metacarpal-phalangeal and interphalangeal joints are kept at their maximum length when the joints are flexed. Splinting in this position reduces fibrotic shortening of the ligaments.

The position of function should be differentiated from the position of dependency and inactivity. A hand in pronation, at rest, exhibits the wrist in a neutral or flexed attitude, the fingers almost completely extended, and the thumb adducted close to the palm. The hand which becomes stiff in this position is crippled. The unsplinted injured hand will assume this undesirable position because of the pull of the relatively stronger flexor muscles of the wrist and the force of gravity. Unfortunately, allowing the hand to stay in this undesirable position for only a few weeks will lead to contractural changes within the joint ligaments and capsules.

As a first-aid procedure, all injured hands should be splinted in the position of function and elevated in a sling or on pillows.

Hand in the "Position of function"

Fig. 2—In this functional position, hand most easily accomplishes grasp and pinch. Note extension of wrist and flexion of metacarpal phalangeal and interphalangeal joints.

Splinting should be maintained until the injury is evaluated and definitive treatment carried out. Except for minor lacerated wounds, without nerve or tendon involvement, the emergency room is not the place to repair the injured hand. The operating room provides the opportunity for adequate anesthesia, asepsis, and assistance.

After definitive treatment, as a rule, the hand again should be splinted in the functional position. Exceptions include fracture of the head or neck of any metacarpal bone, fracture of any part of the metacarpal of the thumb, severance of flexor or extensor tendons, and severance of the median or ulnar nerve.

Many materials—wood, plaster, and metal—may be used to construct a splint. Available prefabricated splints will maintain immobilization in a satisfactory position. The universal hand splint described by Allen and Mason[5] is commercially available.[3] A padded volar splint of wood or plaster extending from the fingers to the proximal part of the forearm, incorporating a rolled abdominal pad to support the palm, can be used if commercial splints are not available (Fig 4).[6]

The dressing for a wound is another protective device. It should prevent additional contamination of the wound, it should absorb

Fig. 3—Lateral collateral ligaments of finger joints. Top. Ligament of extended proximal joint is slack. As joint is flexed proximal end of proximal phalanx passes over volar protuberance of metacarpal head, bringing ligament to its fullest stretch.

blood and exudate to keep the wound dry, and it should provide gentle compression to reduce edema. In particular, thermal wounds of the hand and wrist—in addition to splinting in the functional position—require application of an occlusive compression dressing and elevation of the hand and forearm to counteract edema formation.

The following general principles must be observed in dressing and splinting the wounded hand if good results are to be achieved:

1. Adequate separation of the fingers prevents maceration of the skin from sweat and wound exudate. (This is readily accomplished by tucking 4 by 4-inch gauze sponges between the fingers.)

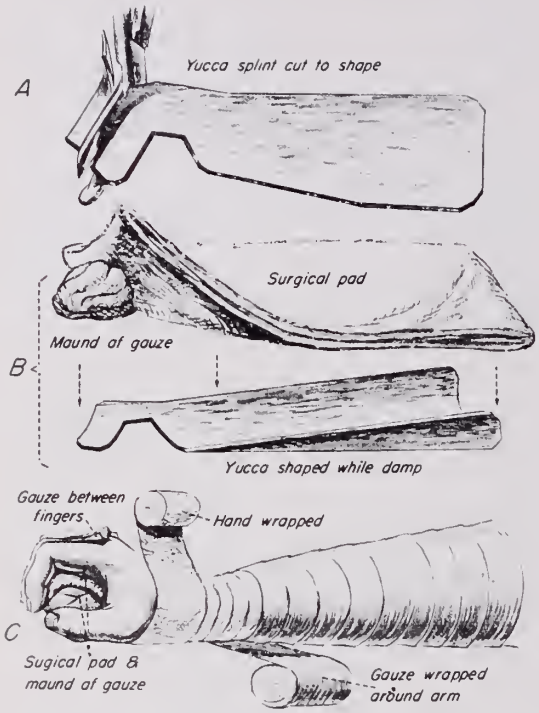

Fig. 4—Application of hand dressing and wooden or plaster splint. Splint is well padded with surgical pad, and gauze is placed between fingers. Dressing should be firm but not constricting. [Reproduced with permission from: Blount, W. P.: Fractures in Children. Baltimore, Williams & Wilkins Company, 1954.]

2. Adequate padding between the splint and the limb prevents maceration, pressure necrosis, and compression of nerves and blood vessels. (The common abdominal pad folded upon itself will serve this purpose.)
3. Broad contact of the padded splint with the injured limb provides for better immobilization and avoidance of pressure points and skin necrosis.
4. Securing the splint with a wide strip of adhesive tape which only partially encircles the forearm prevents the splint from rotating to either side or slipping distally. (This is particularly important when the universal splint is used, for if it slips distally, the fingers will be extended.)
5. Padding placed over the fingers, wrist, and forearm and secured with a loosely expansile bandage such as Kerlex bandage affords gentle compression as well as stabilization of the splint.
6. After application of the dressing and splint, elevation of the hand and forearm minimizes edema and pain. (Minimal elevation may be achieved by placing the hand and forearm in a sling or on pillows. Maximum elevation may be achieved by supporting the upper arm, elbow, forearm, and hand from an intravenous standard or overhead bed frame with a triangular muslin sling or towel; this will be helpful in the event of extensive injury, particularly crushing injury. The supporting sling must not be attached to the hand or forearm dressing itself; otherwise, the dressing will tighten, producing constriction and subsequent congestion, or the dressing and splint may be pulled out of position.)
7. Prompt investigation of inordinate pain after application of a dressing and splint may avoid damage from pressure or circulatory embarrassment.

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APPLICATIONS FOR RESEARCH SUPPORT IN 1966 AVAILABLE FROM AHA

The American Heart Association is now accepting applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1966.

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Further information and application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, New York, N. Y., 10010.

Hernia of the Diaphragm and Chest Wall; Case Report

By JAMES K. THEISEN, M.D. and BERT MILSON, M.D., Green Bay, Wisconsin

■ A 46-YEAR-OLD WHITE man was admitted to the hospital June 16, 1963. He had been involved in a truck accident in May 1962. A large piece of wood pierced his chest wall on the left side laterally near the costal margin. He had been hospitalized elsewhere for two weeks and the chest wall wound sutured. There was no history of a pneumothorax.

A swelling of the left side of the chest wall developed at the site of the injury and became progressively more pronounced and uncomfortable. Further history was not contributory.

There was an 8-cm soft, markedly tender mass in the chest wall anterolaterally over the seventh intercostal space. It enlarged definitely and regularly during the latter two thirds of inspiration when it became moderately tense. The mass retracted somewhat when he was on his right side. A slight widening of the seventh intercostal space was palpable on depressing the mass. Clear lung sounds were audible over the mass, but it could not be determined whether these were transmitted or whether there was herniation of lung tissue. General physical examination revealed no other abnormalities (Fig 1).

X-ray films of the chest including a tangential view of the chest wall failed to reveal any evidence of herniated lung in the soft tissue mass. There was a tiny fleck of calcium in the mass and the possibility of an organized hematoma was considered. The initial impression was that of a traumatic lung hernia with the possibility of a defect in the diaphragm with omental herniation.

Surgery was performed the day after admission, under general endotracheal anesthesia. It was noted that with pressure upon the anesthesia bag the mass became quite large. A seventh intercostal incision was made over the mass, excising an ellipse of skin. A hernial space was entered and found to be filled with omentum (Fig 2).

Fig. 1—Mass in the chest wall on the left side.

Fig. 2—Omentum herniated through a defect in the diaphragm.

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From St. Vincent Hospital.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: CHARLES H. ALTSHULER, M.D.
Milwaukee, Wisconsin

Case Presentation.* A 66-year-old white woman was seen in her physician's office in July 1963 because of vague headaches and facial pain on the right side. She stated that approximately two weeks before, the right side of her face had become numb and the next morning she noted that it had become paralyzed. At the time of her interview, she felt that the numbness had gradually resolved.

Past history revealed that the patient had been a diabetic for 10 years and at the time of the initial examination was on a 1300-calorie diabetic diet and taking 14 units of NPH insulin daily. She checked her urine for sugar occasionally, and claimed that it ranged from 0 to 1+. A fasting blood sugar test had not been done for 4 years prior to her examination. She had had two uneventful pregnancies many years before. In 1957 she suffered a partial paresis involving her right leg and eye. This was thought to be due to a cerebral hemorrhage, and the paresis eventually resolved, but she continued to have intermittent dizzy spells. In the spring of 1961, she developed facial paresis on the left side which cleared rapidly. In July 1961, the patient was operated on for acute appendicitis. The postoperative course was uneventful.

Family history revealed that both parents and two siblings had been diabetic. One sister and two brothers were said to have died with "heart disease."

The patient had noticed for several years that her eyes were puffy. She was always extremely tired and required 13 to 15 hours of sleep per day. Her appetite was poor but her weight remained constant. She was somewhat constipated.

Physical examination showed her to be a well developed, well nourished, rather lethargic, elderly white female. Blood pressure was 160/90 mm Hg, pulse rate 78, and weight 131 lb. Bilateral periorbital edema and a right-sided seventh cranial nerve paresis of the peripheral type were noted. The cranial nerves were otherwise intact. The ocular fundi revealed grade 1 Keith–Waggoner changes. Complete dentures were present. The hair of the scalp and eyebrows was essentially normal. Pubic and axillary hair was sparse. The skin was fine textured. The thyroid gland was not palpable. Deep tendon reflexes were normal.

Electrocardiographic studies showed normal sinus rate and rhythm. The heart was in a semivertical position and within normal limits. Initial laboratory studies disclosed the following values: red blood cell count (RBC) 4,100,000/cu mm; hemoglobin 12.2 gm/100 ml; specific gravity 1.010; acid reaction, sugar and albumin negative; 5 to 8 white blood cells (WBC) per high-power field; blood sugar 109 mg/100 ml; protein-bound iodine (PBI) 1.8 μg/100 ml; cholesterol 346 mg/100 ml; and blood urea nitrogen (BUN) 19 mg/100 ml.

The patient was given meclizine (Bonamine) and dextropropoxyphene (Darvon) compound, and 15 mg of thyroid twice daily was initiated. Over a period of two months, the thyroid dosage was gradually increased to 0.12 gm daily. There was definite symptomatic improvement; the patient felt stronger, required less sleep, and experienced an increased appetite. During this period she lost 10 lb in weight with some decrease in periorbital edema. No other changes in the physical findings were observed.

In April 1964, the patient developed acute upper abdominal pain accompanied by nausea and vomiting. Her temperature rectally was 101 F. Except for right upper quadrant abdominal tenderness and muscle guarding, no significant changes were noted in her physical findings.

She was admitted to the hospital and was treated with parenteral fluids and opiates. She experienced a satisfactory clinical re-

* From St. Joseph's Hospital.

sponse and her symptoms and abdominal findings subsided.

On admission laboratory studies revealed the following values: WBC 10,500/cu mm with a differential count of 80 neutrophils, 12 stab forms, 1 basophil and 7 lymphocytes; total serum bilirubin 4.7 mg/100 ml (direct, 3.4; indirect, 1.3), which subsided rapidly to normal levels; transaminase 46 units; fasting blood sugar 78 mg/100 ml; urine urobilinogen 1.10 mg in 24 hours; alkaline phosphatase 10 Bessey–Lowry (BL) units; cephalin cholesterol negative in 24 hours; serum chlorides 93 mEq/L; carbon-dioxide combining power 28 mEq/L; potassium 4.1 mEq/L; serum amylase 75 units; PBI 1.6 μg/100 ml; and iodine-131 uptake 17.6%.

X-ray films of the heart and lungs showed them to be within normal limits. Upper and lower gastrointestinal (GI) series revealed no abnormality. A cholecystogram revealed a poorly functioning gallbladder with nonopaque stones. The patient was discharged from the hospital on a gallbladder regimen, Donnatal and 0.12 gm of thyroid daily. Insulin therapy was discontinued.

At home the patient experienced continued moderate distress with vague abdominal discomfort, anorexia, weight loss, and nausea. Intestinal functions were normal.

She was readmitted to the hospital in June 1964 for a cholecystectomy. An initial prothrombin time was 28%. This rose to 49% after three days of parenteral vitamin K. Electrocardiographic studies revealed nonspecific ST-T wave changes. An abdominal laparotomy was performed and a gallbladder containing stones was easily removed. In the recovery room, an unexpected prolonged effect of anesthesia was observed. However, vital signs and blood pressure remained normal.

At 12:30 AM of the first postoperative day, the patient's temperature suddenly rose to 104 F (rectally). She was given penicillin and tetracycline (Achromycin) intravenously. By 7:30 AM her temperature had fallen to 100.4 F (rectally), but her blood pressure was 82/40 mm Hg. Shortly thereafter she began to respond verbally, her blood pressure rose to 120/80, and the heart tones were good. Scattered pulmonary rhonchi were heard. At 11:30 AM the patient died suddenly.

Clinical Discussion. *Dr. Samuel Rosenthal:** As I read the protocol, several questions arose in my mind; and several aspects of the clinical situation impressed me. First, the protocol states, "In 1957 she had suffered a partial paresis involving the right leg and eye." This is an interesting observation. I don't know what is meant by a partial paresis of a right eye and a right leg. Notice there is no mention of involvement of the arm. This is most bizarre. We do not know whether this is a facial palsy with involvement of the orbicularis.

Later on, the protocol states that both parents and two siblings were reported to have been diabetic. I think this family history is important because with this type of family history, the patient would be expected to have at least a 50 per cent chance of being diabetic. Next, a right seventh cranial nerve paresis of the peripheral type is recorded. I would assume this is a facial palsy or a Bell's palsy and I think this is an important finding in this case, as I will point out in a moment. "The hair of the scalp and eyebrows was essentially normal and the pubic and axillary hair was sparse. The skin was finely textured." Generally with hypothyroidism, of course, the skin is somewhat thickened or coarse.

The significant laboratory findings are the depression of the PBI and the elevation in blood cholesterol. As noted, the patient was treated with thyroid and a definite symptomatic improvement was observed. She felt stronger, required less sleep, and experienced an increased appetite. Obviously this was a case of hypothyroidism, because the best clinical indication of hypothyroidism is reponse to thyroid. It does not always matter what the PBI is or what the radioactive iodine uptake is, but the response to thyroid is most important.

In April 1964, she developed an acute onset of upper abdominal pain, accompanied by nausea and vomiting and temperature elevation. Her temperature was 101 F (rectally). She was admitted to the hospital and treated in a supportive manner. She experienced a satisfactory clinical response and her symptoms and abdominal findings subsided. This

* This CPC was discussed by Doctor Rosenthal just prior to his untimely death. Doctor Rosenthal was a rare individual—an inspiring teacher, a wonderful doctor, a devoted friend, and a tireless worker for Medicine and St. Joseph's Hospital, where he was on the Attending Staff. He was also an Associate Professor of Medicine at Marquette University School of Medicine. His loss creates an unfillable void.—CHARLES H. ALTSHULER, M.D.

could well have been a gallstone attack. X-ray studies of the heart and lungs were said to be within normal limits. A cholecystogram revealed a poorly functioning gallbladder with nonopaque stones.

As you know, three kinds of stones are formed in the gallbladder. One is the pigment stone which is usually associated with hemolytic anemia and an increase in serum bilirubin; then, there is the cholesterol stone which is usually associated with hypercholesterolemia; and last and the most common, the mixed type which is associated, at least in part, with infection. As a matter of fact, infection is usually a factor, except in a purely hemolytic anemia. The fact that she had had nonopaque stones would suggest that these were cholesterol stones, and might have been related to her hypercholesterolemia and hypothyroidism.

Thyroid therapy of 0.12 gm daily was started and insulin was discontinued. I think this is important. Why should her requirements for insulin suddenly diminish?

She was readmitted to the hospital in June 1964 for cholecystectomy. An initial prothrombin time was 28%, which was definitely depressed. After three days of parenteral vitamin K, it rose to 49%, not a normal level, but it was a fair response. An electrocardiogram revealed nonspecific ST-T wave changes. Significance of ST-T wave changes is difficult to assess. It may be the result of electrolyte disturbance; it may be the result of coronary insufficiency, or it could be due to myocarditis or pericarditis. Because of the cholecystitis and cholelithiasis, an abdominal laparotomy was done and a gallbladder containing stones was easily removed. It is important for us to know whether the surgeon had difficulty in taking out the gallbladder. Usually when we get the operative report, it is so dictated that it looks like the operation was a breeze. But as we all know, this doesn't always reflect the true state of affairs. In the recovery room, an unexpected prolongation of the anesthesia effect was observed. However, the patient's vital signs and blood pressure were recorded as remaining normal. At 12:30 AM of the first postoperative day, her temperature suddenly rose to 101 F. By 7:30 AM her temperature had fallen to 100.4 F, but her blood pressure was 82/40. Shortly thereafter she began to respond verbally. Her blood pressure rose to 120/80 and the heart tones were good. Scattered pulmonary rhonchi were heard. At 11:30 AM she died, about 16 hours after the operation. The appearance of sudden fever the first day postoperatively raises the question of atelectasis, internal hemorrhage, and in a patient with a cholecystectomy, of so-called liver shock, if you want to call it that—a disturbance of the function of the liver. We don't know which it was.

I should like to briefly outline for the house staff a method which I feel is valuable in diagnosing difficult cases, because I feel that although it may be spectacular to pick a diagnosis out of thin air, a good diagnostician has to depend on a systematic approach. The chances of being right are much greater.

Diagnosis involves two procedures: collecting the data and analyzing them. Errors in diagnosis frequently result from inadequate data. If you don't have enough information, you can't make a diagnosis, no matter how smart you are. Secondly, the data may be incorrect, especially the history. You have to evaluate the history in the light of the patient's intelligence and you have to verify it from other members of the family or friends. Thirdly, there may be misinterpretation of the data. Lastly, and most importantly, there may be a faulty analysis.

Dr. C. H. Altshuler: This protocol was written by a clinician, so that if you must complain, complain to him.

Doctor Rosenthal: If it was written by the clinician, we will assume that it was adequate (laughter).

In making a diagnosis, we must, of course, first do a history and physical examination. Perhaps it is trite to say this, but the history is still of prime importance in most diagnoses. In analyzing the facts. we have to list the reliable findings in order of appearance, and then relist them in order of apparent importance. I would like to stress that many an obscure diagnosis will become clear if you put it down on paper. Don't try to work it out in your mind. Write it down. It makes a difference in your thinking. Now then, select one, two, or three central features and then list the diseases in which these phenomena are encountered. What disease or diseases would account for the central features of the clinical story? You must review all of the evidence, both positive and negative, with the diagnosis in mind.

Let us now take up the present case. What are the facts? One, she was 66 years old.

Next, she had diabetes for 10 years and had been treated with insulin. This is important because it raises the question of the possibility that she had arteriosclerosis. With her neurologic manifestations, you must consider that she might have suffered thrombosis of some of the cerebral vessels, even though the picture is peculiar. She had paresis of the eye and a leg, and nothing is mentioned about the arm. Also, she had partial paresis of the right leg and eye in 1957 followed by dizziness. Dizziness is a nondescript symptom. I feel most people may be dizzy in one way or another and it may last for many years. But it raises the question, "Did she have some cerebral arteriosclerosis which caused vascular insufficiency?"

Next, she had a *left* facial paralysis in 1961 which cleared rapidly. This is somewhat unusual. Even Bell's palsy doesn't clear rapidly. It usually takes two weeks to six months for it to clear, and sometimes it remains permanently. Bell's palsy involves the facial nerve and we do not know what causes it. You see it in young people; you see it in old people. Some say it's due to a viral infection. It may be in some cases. Sometimes we see it in people after they have ridden in an open car and gotten wind on their faces. Anyway, she had a facial paralysis. She had had puffy eyes for several years. This was probably due to her hypothyroidism. A *right* facial paralysis had occurred in 1963—this is most interesting because it's rare to have a facial palsy alternate from one side to the other. She had had a good response to thyroid therapy in 1963, and she had fine skin and sparse hair; and last, she developed gallstones in 1964. These are how the symptoms developed in order of appearance. The question comes up, "Did she have arteriosclerosis?" Yes, she did. I would say she had to have. "Did she have thrombosis, at some time or other?" She may have had. We have no proof that she didn't. We have no proof that she did, except perhaps for the history of a lesion in the leg. I don't know anything that would cause paralysis of the leg, or paresis of a leg except cerebral thrombosis, but there is no note made as to whether she had a Babinski's reflex or whether the arm was involved. You usually do not see just the leg involved and not the arm.

Let's take these same facts and relist them in order of importance. I would say that the fact that she had had *left* facial paralysis in 1961 and *right* facial paralysis in 1963 is important in that it is bizarre and unusual to have facial paralyses alternating. Atypical facial neuralgia but not facial paralyses has been described in hypothyroidism.[1] Perhaps we may associate this finding with her hypothyroidism. This atypical facial neuralgia was described by Watts in the *Annals of Internal Medicine* in 1951 as one of the more unusual findings in hypothyroidism. She also had this partial paresis of the right eye. We don't know what that means. That could have been a facial palsy too, or it could have been associated with a small thrombosis. Hypothyroidism appears to be firmly established by: clinical appearance, PBI and radioiodine uptake, and most important, by response to thyroid. Also, there is no question that she had gallstones. These were removed. Last, there is the sudden demise after cholecystectomy. Is there any entity that would account for hypothyroidism, would account for gallstones, and would account for sudden death after operation? Yes, there are several. One very important one is hypopituitarism and I believe that this lady had hypopituitarism. We know that you can get hypothyroidism as the result of pituitary insufficiency. We know that the hypothyroidism in turn could cause the gallstones. Adrenal insufficiency, of course, may result from hypopituitarism and this type of sudden death, with depression of blood pressure, makes me suspicious that this woman had depressed adrenal function.

Another very important fact in retrospect was that she needed less insulin in the course of her illness. She had had diabetes for 10 years, but after a while she didn't need as much insulin. Lessening of insulin need after hypophysectomy is well known—it is the so-called Houssay's phenomenon. Of course, it is true that diabetics, as they get older, may not require as much insulin, but to me it seems most unusual that after 10 years she required no insulin.

In summary, I would say that while it is possible that she might have had other disease, I would have to say that she had: (1) cerebral arteriosclerosis, (2) possible thrombosis of a cerebral artery at one time or other, (3) hypopituitarism, probably statistically on the basis of a chromophobe adenoma, (4) hypothyroidism, and (5) sudden death as a result of acute adrenal insufficiency.

Doctor Altshuler: Does anybody have any questions of Doctor Rosenthal before we go on with the pathology?

Dr. A. F. Kustermann: Did anybody try any carotid pressures on the patient?

Dr. William Baker: I attended the patient and I can say that there was no indication of carotid insufficiency.

Dr. J. F. Wepfer: Was there evidence of diabetic polyneuritis?

Doctor Baker: There was no evidence of polyneuritis.

Dr. G. E. Meloy: Would you please repeat that portion about Bell's palsy and hypothyroidism?

Dr. Rosenthal: Atypical facial neuralgia has been described in hypothyroidism. Perhaps this facial paralysis may be related to the atypical facial neuralgia.

Dr. G. W. Sengpiel: It would be most unusual for a chromophobe adenoma to cause hypopituitarism without significant eye findings.

Doctor Rosenthal: Yes, it would be most unusual because usually there is hemianopia, and this is one of the most important signs. However, occasionally there may be an intrasellar lesion that doesn't press against the clinoid or doesn't extend to the optic tract. This paresis of the eye that cleared up made me feel that maybe she did have eye findings. I must assume that, because there is no mention that the paresis involved her arm and her leg. If it involved her arm, her leg and her eye, I'd say this was a hemiparesis. I've never seen a stroke involving the eye and the leg and not the arm, and I assume that with the dizzy spells she might have had some ocular findings even though there were no changes in her visual fields. I grant that your point is well taken—that in most chromophobe adenomas, the chief symptom is visual disturbance, because it deranges the optic tract by progressive pressure.

Doctor Altshuler: And for Doctor Rosenthal to grant that much is quite generous.

Doctor Baker: The first time I saw this patient she had a right facial paresis of a peripheral type. The history of prior areas of involvement was strictly as she related it to me. It was confusing at the time, but I couldn't make anything more out of it, for this is what she said. The only defect that I actually observed was the right facial palsy.

Doctor Kustermann: She died suddenly?

Doctor Baker: She died very suddenly. Several other doctors and I saw her that morning and she looked well. We walked out and about 20 minutes later, while I was still on the floor, she died.

Doctor Rosenthal: If it weren't for the high fever one might think of pulmonary embolism or coronary thrombosis as the cause of death, but this picture of high fever and hypotension right after the operation strongly suggests adrenal insufficiency.

Doctor Baker: They called me about 7:30 in the morning and told me that she was comatose and febrile, and that she was in shock. I came right over, but by the time I arrived she was no longer in shock and she hadn't been given anything for shock. Her skin was dry and her pulse was quite full, her blood pressure was 120/80 and her heart was regular. There was no evidence of shock during the rest of the morning until she died. The lowest her blood pressure got was 82/60.

Doctor Rosenthal: I think one must remember that patients who are hypothyroid may be very intolerant of many drugs and may die suddenly.

Dr. R. Viel: May we ever expect to find hypopituitarism on the basis of arteriosclerosis?

Doctor Rosenthal: Yes, I could see where you might encounter that situation. However, it would be most unusual. The so-called Sheehan's syndrome is on the basis of postoperative shock and thrombosis. Of course, if there was thrombosis on the basis of arteriosclerosis and it cut off the blood supply to the pituitary, this would have the same effect. This is a possibility.

Dr. P. E. Parker: I am wondering if there is a possibility, since we talked about a pituitary tumor, that this could possibly be a TSH-secreting tumor, even though we have symptoms of hypothyroidism here. Many of the symptoms, including the eye findings, might be a manifestation of a hyperthyroid myopathy. There was no further comment made but she had had nausea and vomiting and other factors which are consistent with excessive thyroid hormone.

Doctor Baker: She did not have a myopathy. She had a facial paralysis. She did not have an ocular palsy. Her third, sixth or fourth nerves were not involved. It was the seventh nerve which was involved. This is not an ocular palsy.

Dr. P. L. Osler: Did the patient have true vertigo?

Doctor Baker: The patient did not have vertigo. She had vague feelings of light-headedness and dizziness.

Doctor Meloy: Doctor Rosenthal, the fact that she died suddenly is part of your argument for the diagnosis, but prior to the time she died, would there be enough evidence here to indicate that she had hypopituitarism as the basis for all of her troubles, rather than just hypothyroidism?

Doctor Rosenthal: No, I don't think so. I admit that I've taken the picture as a whole, and I have had the advantage of having observed the clinical course, an advantage that Doctor Baker didn't have. I consider that this type of death represents a diagnostic feature of this case. Without that sudden death, one probably couldn't go beyond hypothyroidism, gallstones, and probable cerebral thrombosis. These are the only logical diagnoses you could make from the protocol; but looking at the complete picture I think hypopituitarism is a consideration.

Pathologic Findings. *Doctor Altshuler:* On external examination at autopsy, the outstanding features were the marked pallor and the sparsity of body hair to the point of complete hairlessness. The eyes were quite puffy and the skin, as was stated, was finely textured. As a matter of fact the skin looked as if it belonged to an individual who was approximately 30 years old. The heart weighed 300 gm. Severe coronary arteriosclerosis with marked coronary occlusive disease was noted and extensive interstitial myocardial fibrosis was also seen. The lungs were focally atelectatic, particularly in the dependent portions, and moderately emphysematous. The hilar lymph nodes were enlarged, but soft, and no remarkable abnormality was noted in the liver or pancreas. The spleen weighed 350 gm and was somewhat softened and diffluent. Great difficulty was experienced in finding the adrenals as they were markedly atrophied. The right kidney weighed 150 gm and the left kidney 100 gm. The left contained numerous, varying-sized, depressed scars on its surface with deep pits, and the renal pelvis was somewhat widened. The calyces were blunted. The vessels at the base of the brain showed no arteriosclerosis. The sella was somewhat widened and very shallow and the tissue in the sella was fibrotic.

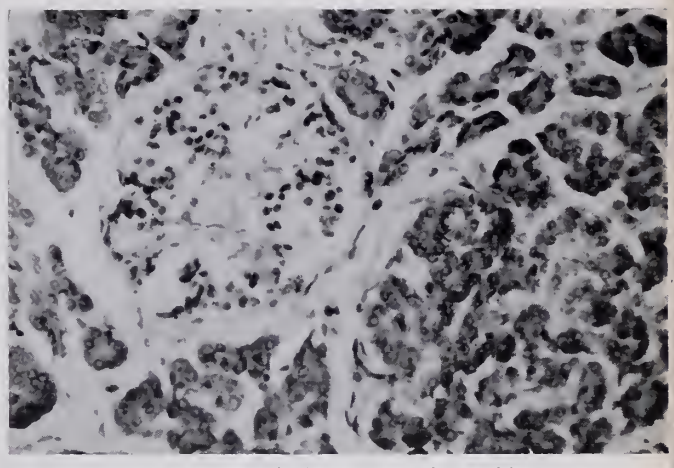

Fig. 1—Pancreas. Characteristic fibrosis noted in the islets of Langerhans.

Fig. 2—Adrenal. Note the severe atrophy of the cortical layers.

On microscopic examination of the pancreas (Fig 1) the islets of Langerhans contained areas of fibrosis similar to those often seen in diabetics. This is a low-power magnification of the adrenal gland showing the marked degree of atrophy that had occurred. Figure 2 is a high-power view and here one can see that the characteristic zonation of the adrenal gland is somewhat obscured. One can't really pick out the zona glomerulosa, fasciculata, and reticularis. It is believed that the zona glomerulosa is not under control of the pituitary gland, that only the zona fasciculata and zona reticularis are. The zona glomerulosa is the area which is supposed to produce aldosterone. This is a low-power view of the thyroid gland and here one sees that although the acini are fewer in number than normal, they are fairly

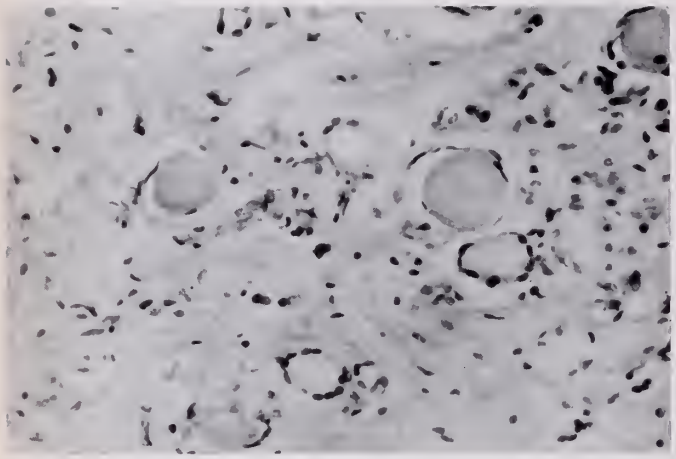

Fig. 3—Thyroid. Marked interstitiol hyaline fibrasis was observed in the thyraid. The acini were well filled with an eosinaphilic callaid.

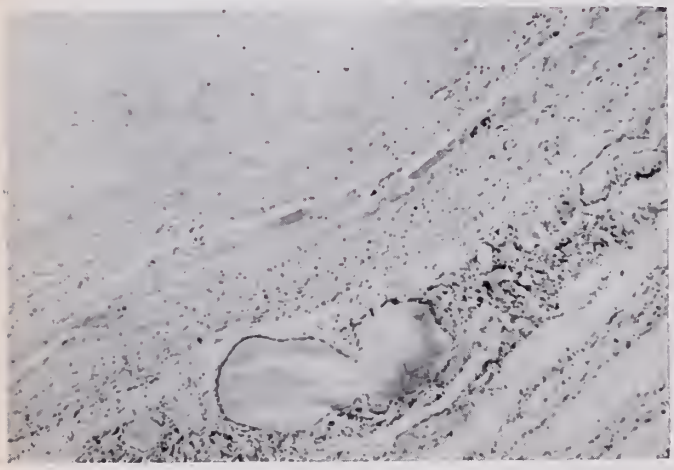

Fig. 4—Pituitary. Severe widespread fibrasis noted in the anteriar lobe af the pituitary. Only tiny fragments of vioble pituitary tissue were recognized The posterior lobe was not remarkably affected.

well-filled with colloid. Marked interstitial hyaline fibrosis can be seen. Figure 3 is a high-power view of the thyroid gland showing the characteristic acini. The lining cells are cuboidal in configuration and do not show evidence of hyperfunction. In Figure 4 one sees marked hyalinization of practically the entire anterior lobe of the pituitary gland. In the intermediate lobe, small characteristic cysts are seen. In other areas, only tiny remnants of recognizable pituitary tissue are retained. The posterior lobe of the pituitary is rather normal in appearance.

The patient, we feel, had diabetes, developed pituitary necrosis, and subsequently hypothyroidism, and adrenal insufficiency became manifest. In 1956 Brennan, Malone and Weaver, writing in *Lancet*, described a series of cases in which this phenomenon occurred.[2] Their patients for many years had diabetes and subsequently and by some unknown mechanism developed pituitary necrosis. These patients, too, went on to demonstrate the peripheral manifestations of hypopituitarism. So Doctor Rosenthal was absolutely right and I wish to thank him for his illuminating and edifying discussion. As usual, he spoiled my whole day.

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A new CPC motion picture, the second of its type designed to permit audience participation and discussion of a special clinical case, is now available on free loan from The Wm. S. Merrell Company, Cincinnati, Ohio.

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Antihistamines Revisited

By CHARLES E. REED, M.D.
Madison, Wisconsin

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

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■ IN RECENT YEARS new understanding of the mechanism of allergic diseases has clarified the meaning of many older clinical observations on antihistamines and has enabled physicians to use those agents more rationally. It is now known that anaphylaxis is the end result of a complex series of enzyme reactions initiated by antigen-antibody complexes. These enzymes in turn release histamine and several other low molecular weight mediators which finally affect blood vessels, smooth muscle and glands.[1] Histamine no longer dominates the center of the stage in the allergic drama but is still often seen as a supporting character playing a bit part.

For example, antihistamines are rarely helpful in terminating or preventing attacks of asthma even when the attack is clearly provoked by allergy. In asthma a major mediator appears to be slow-reacting substance, an acidic lipid molecule whose action is not blocked by antihistamine drugs. However, it is likely that the major abnormality in asthma is not so much excessive release of these mediators as it is an abnormally vigorous response to their effect. Aerosols of acetylcholine, histamine, slow-reacting substance, bradykinin, and serotonin which have no effect in normal persons provoke airway obstruction in people with asthma.[2]

Antihistamines have also been disappointing in the treatment of angioneurotic edema. As is so often the case, study of a rare hereditary disease has improved our understanding of mechanisms of commoner problems. Hereditary angioneurotic edema has been shown to be the result of congenital deficiency in the synthesis of a normal protein inhibitor of one of the enzymes of the complement system.[3] This inhibitor also blocks the enzymatic release of bradykinin, a polypeptide which is more potent than histamine in producing vasodilatation and increasing capillary permeability. In the absence of this homeostasis-promoting inhibitor the cell damaging effects of the complement system and the actions of bradykinin proceed at an accelerated pace and angioneurotic edema occurs. While the levels of this inhibitor are normal in cases of nonhereditary angioneurotic edema, the similarity of the lesions makes it likely that the complement system and bradykinin are involved here, too. The vascular injury in some cases of urticaria, especially those associated with serum sickness, also appears to be mediated by bradykinin or enzymes of the complement system.

Other allergic diseases are the result of processes quite different from anaphylaxis. Rheumatic fever, glomerulonephritis, rheumatoid arthritis, lupus erythematosus and other "auto-immune" diseases are included in the growing list of diseases of unknown cause in which tissue damage by immune mechanisms has been demonstrated or suspected. The details of the mechanism of the tissue damage are as yet far from clear, but it is highly unlikely that anaphylactic release of histamine from mast cells is an important event. In any case, the antihistamines have not proved useful in treating this group of diseases.

Dermatitis venenata from poison ivy is the commonest example of contact dermatitis, a prototype of a third category of allergic disease. The tissue damage here, as in all delayed allergic reactions, is brought about by lymphocytes and not by circulating antibody. Release of stored histamine from mast cell granules does not occur. Thus, the antihistamines, *as antagonists of histamine*, have no place in the management of contact dermatitis; although as we shall see later, pharmacological effects other than blockage of

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histamine may make them useful in special circumstances.

We are left, then, with a short list of common diseases in which histamine is a prime mediator and which generally respond at least partially to blockade of the effect of histamine on effector cells by antihistamines.

Anaphylaxis. Epinephrine is by far the most important agent for treatment of this emergency, but antihistamines in generous parenteral doses are a valuable addition. In guinea pigs, pretreatment with antihistamines will largely prevent anaphylaxis, but it is most unwise to rely on antihistamines to prevent anaphylaxis in humans. Anaphylaxis is better prevented by avoiding injection of suspected antigens. Nevertheless, pretreatment with antihistamines has been shown to reduce the incidence of urticaria and shock following intravenous injection of contrast agents for radiographic examinations.[4]

Hay Fever. Antihistamines are effective in about 80 per cent of cases of hay fever. Many textbooks state that for an individual patient one antihistamine will often be more effective than another. My own experience has been that this is rarely the case, but that increasing the dose or adding an oral sympathomimetic vasoconstrictor such as pseudoephedrine or phenylephrine hydrochloride is likely to be more effective than switching from one antihistamine to another. They are also more effective if given on a regular regimen for prevention of symptoms rather than sporadically after the symptoms have already started.

Tachyphylaxis commonly occurs when the drug is given regularly for more than a week or two. At that time it may be helpful to change to another antihistamine. The accompanying table provides a classification of the commonly used drugs based on their chemical structure. If a change is to be made the second drug should be selected from a different group. The drugs in groups I and V are more likely to cause sedation than the others. Because the phenothiazines can provoke serious reactions of photosensitivity, hepatitis, and bone marrow injury with agranulocytosis, it is wise to avoid them whenever a less toxic drug is effective. Dermatitis, photosensitivity, agranulocytosis and hemolytic anemia have been reported following the use of *tripelennamine*, diphenhydramine as well as several other antihistamines, but these reactions are exceedingly rare.

TABLE 1—*Classification of Commonly Used Antihistamines**

Group I—Oxygen-linked Dimethylaminoethylenes
Diphenhydramine (Benadryl)
Dimenhydrinate (Dramamine)
Doxylamine (Decapryn)
Group II—Nitrogen-linked Dimethylaminoethylenes
Pyranisamine (Neo-Antergan)
Thonzylamine (Neohetramine)
Tripelennamine (Pyrabenzamine)
Thenylpyramine (Thenylene, Histadyl)
Group III—Carbon-linked Dimethylaminoethylenes
Chlorpheniramine (Chlor-Trimeton, Teldrin, Ornade)
Brompheniramine (Dimetane)
Pyrrobutamine (Pyronil)
Dimethindene (Forhistal)
Group IV—Nonrelated
Chlorcyclizine (Diparalene, Perazil)
Phenindamine (Thephorin, Dristan)
Hydroxyzine (Atarax, Vistaril)
Cyproheptadine (Periactin)
Group V—Phenothiazines
Promethazine (Phenergan)
Methdilazine (Tacaryl)
Trimeprazine (Temaril)

*Modified from Sheldon, Mathews & Lovell, W. B. Saunders & Co., 1953, *A Manual of Clinical Allergy*.

Urticaria. In general these same comments apply to urticaria. Hydroxyzine (Atarax, Vistaril) is sometimes considerably more effective than the other antihistamines in treating urticaria.[5]

In chronic urticaria the response to antihistamines is often disappointing, presumably because histamine is not the only mediator of the vasodilatation and increased capillary permeability.

Other Pharmacological Effects. It is of interest to note in passing that the stimulation of gastric secretion by histamine is not blocked by the antihistamines. These drugs have many actions unrelated to the antagonism of histamine. Many are anticholinergic to some degree, which accounts for the drying of secretions which is often observed. Because of drying they are contraindicated in those cases of asthma in which mucous secretion is important in producing the airway obstruction.

They are also potent local anesthetics. Tripelennamine is used for topical anesthesia of mucosal surfaces. The antihistamines are frequently applied to the skin to relieve pruritus. Unfortunately, like all local anes-

thetics, the antihistamines commonly cause contact dermatitis. Sensitization is especially likely to occur when the agent is applied to inflamed skin. This hazard of allergic sensitization to antihistamines applied topically is a very real one and their topical use should be discouraged. Diphenhydramine (an ingredient of Caladryl) is now one of the most frequent causes of contact dermatitis recognized in our clinic.

The antihistamines have poorly understood and often unpredictable effects on brain function. Most of them cause drowsiness in some patients, and many patients complain of irritability and insomnia. On the other hand, the central nervous system action is often desirable. These drugs, especially those in groups I and V, will often alleviate motion sickness as well as nausea and vomiting from other causes. They have been reported to be effective in relieving pruritus, but it is difficult to be certain that this effect is much greater than a placebo.[6] Many of them, especially the phenothiazines, have a place in the management of mental illness, a topic beyond the scope of the present discussion.

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HERNIA OF DIAPHRAGM AND CHEST WALL

continued from page 251

Fig. 3—Retractar in the diaphragmatic defect.

The pleural space was entered posterior to the hernia and the diaphragm was found to be adherent to the chest wall at the periphery of the defect. After this was dissected free, the defect in the diaphragm measured 8 x 5 cm. The omentum was reduced into the abdomen through this defect (Fig 3).

There was only a very thin rim of diaphragm peripheral to the defect so that the periosteum was incised and reflected off the rib to strengthen the peripheral rim of diaphragm. This was included in the repair which was carried out with No. 2–0 silk mattress sutures. A portion of the costal cartilage between the seventh and eighth ribs was excised to provide for a more close approximation of the ribs, using No. 1 chromic gut as pericostal sutures. The postoperative course was uneventful. A chest x-ray film taken on July 22, 1963, was reported as negative.

637 South Monroe Avenue.

* * *

"Research in the United Kingdom pharmaceutical industry, which has been increasing at 20 percent a year in the five years beginning in 1956, has now slowed down. The main reason is the unsatisfactory state of patent law and practice, especially the regulation that allows a company to apply at any time for a compulsory license from a firm which may have spent large sums of money to develop a particular drug."—(Financial Times of London, January 13, 1965.)

Nurse Responsibility in Maternal and Child Care

EXPLANATORY PREFACE: As an outgrowth of the Wisconsin Maternal Mortality Survey, the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments, with Council approval, initiated an ad hoc study, with representatives from the Division, the Wisconsin Hospital Association, and the Wisconsin Nurses Association serving on the special committee.

The report of this committee is given below. The statement has been approved by the House of Delegates of the State Medical Society, by the Wisconsin Hospital Association, and by the Wisconsin Nurses Association.

It is important to explain that these are recommendations, and not directives. Each medical staff, in conference with nurses and hospital administration, has been urged to implement these recommendations in light of local resources and needs. The Division hopes that each hospital will review its existing rules and incorporate as many of these recommendations as possible.—JOHN R. EVRARD, M.D., Chairman, Division on Maternal and Child Welfare

■ WITH THE CONSTANT change in medical, nursing, and hospital services to mothers and children, misunderstandings and misinterpretations relating to practice have arisen between the various disciplines providing service. This Ad Hoc Committee, representing medical, nursing, and hospital groups, was established at the suggestion of the Maternal Mortality Study Committee (a subcommittee of the Division on Maternal and Child Welfare of the Commission on State Departments) to review selected responsibilities which nurses are being asked to assume, and to make recommendations.

It was directed to give primary attention to safeguarding the welfare of mothers and children. Also to bear in mind that "*diagnosis and treatment*," as defined by law, are the responsibility of the physician and *cannot be assumed by the nurse* and, that the practice of nursing, also defined by law, may or may not permit nurses to perform certain procedures heretofore considered medical practice. If the nurse can accept these responsibilities, what instruction is needed so as to safeguard the patient, physician, and nurse?

Analgesia and Anesthesia

The giving of an anesthetic agent to an obstetric patient creates hazards both from the anesthetic agent and aspiration of vomitus. Deliveries sometimes occur when an anesthetist is not available, and nurses are being asked to assume responsibility in the administration of anesthesia for which they are not prepared.

Recommendations of the Committee

1. The most qualified individual available should administer anesthesia. This includes the anesthesiologist, the Certified registered nurse anesthetist and, if in accordance with local practice the physician having knowledge of anesthesia.
2. If an anesthesiologist, Certified registered nurse anesthetist, or physician having knowledge of anesthesia is not available to administer the anesthesia, a Registered nurse who shall have been properly instructed* may administer inhalation anesthesia under the direct supervision of a physician having knowledge of anesthesia, if it does not produce a surgical plane of anesthesia and does not eliminate protective reflexes (swallowing and coughing).
3. Self-administered analgesia by the patient should be used only on written or telephone order of the physician, *under direct bedside supervision of a properly instructed* person*, and under the supervision of a Registered nurse.
4. Trichlorethylene (Trimar, Trilene) should be self-administered *by the patient only*, and should not be followed by the use of carbon dioxide-soda lime absorption technique to administer an anesthetic agent.
5. Local and spinal anesthesia should be given by the physician.
6. Resuscitation of infants is the primary responsibility of the physician, with the help of properly instructed* assistants.

Intravenous Fluids and Blood Transfusion

Intravenous fluids and blood transfusions have become accepted means of saving lives in case of hemorrhage. The time element is a very important factor in getting a large enough needle into a rapidly collapsing vein.

Recommendations of the Committee

1. A written policy for having and obtaining compatible blood and having emergency intravenous fluids for every patient should be established jointly by medical and nursing staffs, laboratory

* "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting criteria established jointly by the medical staff, anesthesiologist and Certified registered nurse anesthetists, nursing staff, and hospital administration, covering the administration of anesthetic agents, the maintenance and care of patient's airway, and administration of artificial respiration with anesthetic bag and mask. The qualification for such instruction would be
(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course be in writing and approved by the executive committee of the medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

personnel, and hospital administration. The following should be considered in the criteria.

a. Every patient should have an Rh determination in the ante partum period and this information made available to hospital personnel on or before admission to hospital.
b. Hospital personnel on all shifts should have knowledge of and ready access to sources of blood and fibrinogen.
c. Only a physician may do a cut down.
d. *In an obstetric emergency* a Registered nurse (who shall have been "properly instructed"*) may start intravenous fluids, e.g., 5% glucose in distilled H_2O or fluids established by each hospital's medical staff, without obtaining a specific order by the physician. *In case of severe hemorrhage* the Registered nurse (who shall have been "properly instructed"*) may administer properly typed and cross matched or Type O Rh negative blood (never a blood expander) without a specific order by the physician.
e. A Registered nurse who shall have been properly instructed* may administer properly typed and cross matched blood on the physician's written order.
f. The administration of blood should be under the direct supervision of a physician or Registered nurse at patient's side for at least the first 15 minutes. The patient should be checked regularly, as indicated by the condition of the patient, until the transfusion is completed.
g. If any adverse symptoms occur, the Registered nurse must stop the flow of blood and notify the physician and laboratory immediately.

Injections and Immunization

Some persons have untoward reactions to many of the common drugs and biologicals. The following recommendations are concerned with these possible reactions to drugs or biologicals, rather than the act of giving the immunization or injection by the nurse. Each injection should be individualized. Recognizing that this may be difficult in mass immunization clinics, provision should be made for at least minimal screening by a responsible adult, parent, teacher, nurse, or physician.

Recommendations of the Committee

1. Immunizations

A. Public Health Immunization

Because of the possibility (even if remote) of individual reactions to biological agents used, the following criteria should be established:

(1) The immunization clinic should be conducted according to written order of the local health officer (if a physician) or the County Medical Society specifying type of injections, age groups, materials and dosage, medical coverage, and referral procedure.

(2) A physician should be in attendance at the clinic site so long as injections are being given.

(3) A Registered nurse, properly instructed†, may give the injections *if a physician is in attendance at the clinic site.*

B. Industrial Health and Employee Health Programs

(1) A physician should be in attendance at the clinic site so long as injections are being given.

(2) A Registered nurse, properly instructed†, may give the injections *if a physician is in attendance at the clinic site.*

C. In the Physician's Office

The office nurse is an employee of the physician and is his legal responsibility. He should see that she shall have been properly instructed† and gives injections only on written general or specific orders.

D. Mass Screening for Tuberculosis

Same basic principles outlined under A., with the exception that a Registered nurse, properly instructed†, may conduct these clinics with or without a physician being present.

2. Injections

A. The Pharmacy Committee of the hospital or local medical group should make a list of drugs used in treating the sick that require a physician's presence.

B. Except for those drugs listed by the Pharmacy Committee, a Registered nurse or Trained practical nurse may give injections upon the written order of the physician specifying the

* "Properly instructed" indicates a course of instruction, demonstration and supervision meeting criteria established jointly by the medical and nursing staff, laboratory personnel, and hospital administration, covering the administration of intravenous bloods and fluids; the proper checking of blood, amount to be given and rate of flow, vital signs and symptoms (TPR, BP, etc.); reaction symptoms that might occur (abdominal pain, chills, etc.); emergency measures that might be required before the physician arrives; and follow-up measures upon completion of transfusion (BP, etc.). The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

† "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting the criteria established jointly by medical and nursing groups, covering the administration of drugs or biologicals (intramuscular, intradermal, etc.), untoward reactions, contraindications for use of drugs or biologicals, precautions, and follow-up. The qualification for such instruction would be

(a) designation of a specific person as instructor who is qualified to teach the above mentioned techniques
(b) course be written and approved by the executive committee and the medical and nursing staff
(c) a record be made and signed that the individual nurse has been properly instructed.

name of the patient, the medication, dosage, time of dosage, etc.

C. A Registered nurse experienced in vena puncture may give certain intravenous medications on written order of a physician. The Pharmacy Committee should list medicines that require a physician's presence.

Vaginal Examinations

These recommendations supplant the statement of the Wisconsin Mortality Study Committee, WISCONSIN MEDICAL JOURNAL, January 1964, page 57.

Recommendations of the Committee

1. ROUTINE vaginal examination by Registered nurses on patients in labor is NOT RECOMMENDED.
2. Where the procedure has been approved by the medical staff, a physician should direct and permit a Registered nurse to perform such an examination only if she shall have been properly instructed.*

Oxytocics

The Maternal Mortality Survey and Study Committee, which is a subcommittee of the Division on Maternal and Child Welfare of the State Medical Society's Commission on State Departments, has been aware for the past several years that oxytocic substances, when used for the stimulation, acceleration or initiation of labor, have associated with their use for these purposes certain potential dangers, specifically that of occasionally causing rupture of the uterus.

Since rupture of the uterus constitutes an emergency of the most extreme import, that Committee has recommended to hospital staffs that when these substances are given for the above purposes the physician *(or an "adequate medical substitute"†)* be in attendance or within the hospital for *immediate contact*, and that the nurse be requested to administer these substances only under these conditions.

Since the potential danger of these substances applies to all of those being currently used, and to whatever route of administration, the recommendation is that they be administered by the Registered nurse only when the physician is physically present either at the locality where they are being given or in the immediate vicinity so that he can be reached in case that a serious emergency occurs.

In view of the serious nature of this problem, recommendations are:

1. Support for Wisconsin State Administrative Code H 26.063(2) which reads:
   "OXYTOCICS. Nurses or other non-medical personnel shall not administer oxytocics to antepartum patients unless a physician is present."
   a. This means oxytocics administered by *any* means—buccal, basal, oral, intramuscular, or intravenous.
2. Medication should be discontinued if the physician (or his "adequate medical substitute") is not *immediately available* (within the unit or hospital).
3. Only nurses who shall have been properly instructed‡ should stay with patients who are being medically induced in labor.

* "Properly instructed" indicates a course of instruction, demonstration, and supervision meeting criteria established jointly by the medical and nursing staff and hospital administration, covering a technique for vaginal examination which will not introduce infection in birth canal, and when not to do vaginal examinations (bleeding, etc.). The qualification for such instruction would be
(a) designation of a specific person as instructor who is qualified to teach the above mentioned technique
(b) course be in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

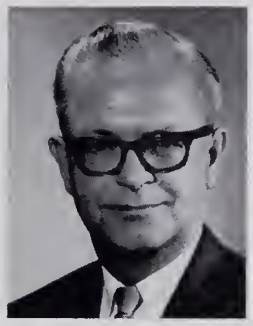
† "Adequate medical substitute" means a physician well enough versed in obstetrics to properly handle medical emergencies commonly resulting from adverse reaction to administered oxytocics.
(a) Intravenous drip is a much safer procedure than other methods of administration, and permits the best discontinuation of drug.
(b) Buccal is a new method of administration. In event of an adverse reaction the tablets should be removed and mouth thoroughly washed.
(c) Nasal pledgets should be removed, in event of adverse patient reaction.
(d) Intramuscular and oral are the least desired since the effects of drugs continue until dosage is absorbed.

‡ "Properly instructed" indicates a course of instruction, demonstration and supervision meeting criteria established jointly by medical and nursing staff and hospital administration, covering the effects of this drug upon the patient's labor and the necessity for checking pulse and respiration, blood pressure every 15 minutes, fetal heart every 5 minutes, and timing of duration, length and intensity of contraction. The qualification for such instruction would be
(a) designation of a specific person as instructor who is qualified to teach above mentioned techniques
(b) course be in writing and approved by the executive committee of medical staff and hospital administration
(c) a record be made and signed that the individual nurse has been properly instructed.

DRUG EFFICACY—WHO'S TO SAY?

The (new drug) law should be modified by the deletion of F.D.A. responsibility for "efficacy". The final approbation or disapproval of a drug should be in the hands of the medical profession and not the F.D.A. In addition, there are many officials of the F.D.A. who should reassess their relationship to the pharmaceutical industry in the light of the sound philosophy that a successful democracy is more than a form of government; it is a behavior pattern which stems from the "Golden Rule".—JOHN C. KRANTZ, JR., Ph.D., in *Military Medicine*, 130:1, (Jan.) 1965.

THE PRESIDENT'S PAGE . . .



J. H. HOUGHTON, M.D.
Wisconsin Dells

Medicare

■ HAVING JUST RETURNED from the A.M.A. meeting in New York, I am impressed with the many divergent ideas on how best to handle Medicare—now, and when and if it becomes the law of the land.

There are those in our profession—sincere, well meaning and able individuals—who believe we should take a militant stand *now* against the principle of Medicare. They have many valid reasons for believing as they do. As one listens to their presentations, one cannot help but feel respect for their logic and their reasoning in support of their views.

Of course, we're against the principle of Medicare! We, as a profession, have stated this time and again. And we have clearly given our reasons for this opposition. The Nation knows this and so do our Legislators. It is my belief that we, as a profession, have convinced the Nation. However, our Legislators—even though they know in their hearts that this is bad legislation—are determined to put through some type of socialized care for those 65 and over, because they believe that this is one of the reasons they were elected.

I was particularly impressed by one physician who, during discussions before a reference committee, brought up a point that I hope I can interpret clearly. He stated that nowhere in the proposed bill is there any provision which says that a doctor *must* do this, or *must* do that. The bill, as presently drafted, merely states that in order to qualify for hospital care, the patient must have certification by a Doctor of Medicine that hospitalization is necessary. It does not say that a Doctor of Medicine is compelled to do this by law. In other words, he reasons that we will be drawn into this, not by law, but by our humanitarian adherence to our code of ethics. Once we have complied even one time with this requirement, we will have given implied consent to the law.

On the other hand, there are those in our profession, and I belong to this group, who say we should not waste our ammunition until we know specifically at what we are shooting. Certainly we are opposed to the whole principle, but everyone knows this. To talk about nonparticipation now is premature and not really logical until we know exactly in what we are not participating.

The position finally adopted by the A.M.A. at its June meeting in New York is as follows: "*Resolved,* that the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality, and availability of medical care which has been traditional in our country; and be it further *Resolved,* that when the fate of the pending Medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary."

I heartily agree with these resolutions and further recommend that, if necessary, our Wisconsin House of Delegates be called into special session to determine Wisconsin's stand at that time.

By the time this article appears, Medicare may have been passed by both the House and the Senate, but I believe that anything I have said will still apply.

There is one thing that must be emphasized, and that is, that no matter what our final stand may be, it is mandatory for every Doctor of Medicine in our state and in the nation to make sure that our patients do not suffer in their medical needs because of whatever disagreement there may be between the Government and the Medical Profession.

J. H. Houghton, M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Dream Not Quite Realized

■ NEWSPAPER REPORTS recently told of the signing of five contracts for construction of the new Middleton medical library on the campus of the University of Wisconsin at Madison. The library is scheduled for completion in the 1969–71 biennium and will cost about $1.7 million. Of this amount, about half is being provided by gifts made to the Wisconsin Medical Alumni Association and by earnings on invested gift funds. The other half is coming from state taxes.

A new medical library in Madison has been a long recognized need. About four years ago, the Medical Alumni Association began to raise funds to build it. The original goal was $400,000, but it was soon realized that more money would be needed. As the required amount was increased, and as more money was raised, delay after delay was encountered. It is therefore gratifying to learn that construction on the building will soon begin.

As news of the contract approval was received, there also appeared the results of a continuing study by the Association of American Medical Colleges which underlined the need not only for the new library as it is planned, but for expansion of the present project. Briefly, the report indicates that since 1953 medical libraries have been unable to keep up with the growing volume of medical literature. As medical knowledge proliferates, as more funds and more brains are directed to scientific research, the volumes of books dealing with health care stack higher than ever. The need for space to store the books, for money to buy the books, for personnel to catalog and bind the books goes up in direct ratio to the growth of medical knowledge.

Specifically, the study made in 1965 indicates that the average medical school needs additional space of 32,000 square feet and reports an average need of 18,000 additional volumes and periodicals. Besides these space and volume requirements, the average school reports a requirement of $132,000 more than their present budgets for cataloging, binding and other instructional media or equipment. This does not include the additional costs of staffing, equipping, and maintaining the expanded facilities implied by increases in space and volume holdings.

Views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

No medical college—or any other kind of school—can function without an adequate library. While it is pleasant to learn that the Middleton library is at long last underway, it should be recognized that the start of construction on the building is only the beginning of a library we can be proud of. As medical knowledge accumulates, the library must be supplied with funds to buy the books in which the mounting tide of biomedical information is preserved and disseminated, and to provide the space in which to store them.

Now that the building of the library has begun, it is to be hoped that doctors will continue their gifts to the Wisconsin Medical Alumni Association to maintain the library so that it can keep pace with the science it serves. —D.N.G.

Spotlight On Perfidy

■ DESPITE OPPOSITION from the American Medical Association and a roster of specialist organizations, the Senate Finance Committee recently approved a change in the so-called Medicare bill (HR-6675) which, more than any other single provision, may have a tragic effect on the practice of medicine.

The committee approved an amendment to the bill as passed by the House of Representatives which would include the services of radiologists, pathologists, anesthesiologists and physiatrists as part of hospital care under social security. According to Senator Paul Douglas, a Democrat from Illinois, who has never been famous for his affection for the medical profession, the amendment provides that where the hospital and the specialists agree that their services are to be included in the hospital's treatments, their fees will be billed as hospital care by the hospital under Plan A (hospital care under social security.) Where specialists and hospitals do not agree, the specialists' fees will come under Plan B (voluntary government insurance.)

The amendment was backed by the American Hospital Association, Blue Cross, AFL-CIO, American Nurses Association and the Secretary of Health Education and Welfare, Anthony J. Celebrezze, who told the Senate committee that not including the physician specialties as hospital care in the House bill was a mistake.

The committee's approval of the amendment is regrettable, and it is to be hoped that the final version of the bill will follow the pattern of the House measure. The House of Representative's bill, as passed, carefully avoided placing medical services under social security, wisely restricting the encroachment of tax-supported health care on the free practice of medicine.

But such wise restrictions were apparently galling to the American Hospital Association which seems to be seeking complete control of health care in this country. Although the American Hospital Association speaks beguilingly of the doctor-hospital "team effort," it apparently will stop at nothing less than complete control even though it means the ruin of the system of medical relationships that exist today. The manifest policy of the American Hospital Association appears to be that the hospital is the community's health center, and that the services of physicians and surgeons are a function of the hospital. By locking in radiologists, pathologists, anesthesiologists and physiatrists as hospital employees, the amendment provides a precedent for including all medical personnel as hospital employees, whose services are to be billed along with room and board fees.

The medical profession has always insisted that the physician has ultimate responsibility and therefore full authority for medical care—whether in hospitals or outside of them—and that no organization could sell the services of physicians and surgeons for its own profit. The American Hospital Association has also spoken of its abhorrence of corporate medicine, but its behavior has indicated its eagerness to undertake the enterprise.

The attitude of the American Medical Association as well as the State Medical Society of Wisconsin has never varied in its opposition to the merchandising of physicians' services. At stake is the control of the quality of health services: whether it will remain in the hands of qualified medical personnel or whether it will be grasped by non-medical administrators. If the American Hospital Association is sincere in its subscription to the preservation of high quality medical care

in this country, it should cooperate in the effort to keep the practice of medicine where it belongs. Physicians are not technicians, and they can't be considered hospital employees without serious damage to the calibre of service they offer. The amendment to the Medicare bill, which reduces 15% of the nation's independent physicians to the status of hospital employees, is a long step in the direction of inferior medical care. If the American Hospital Association truly believes in the essentiality of the team-effort of the doctor and the hospital, it should end its attempt to subordinate the doctor member of the team. —D.N.G.

Roar from the Right

■ NOW THAT "Medicare" (HR-6675) has been passed by the House of Representatives and it may be only a matter of time before it is voted into law by the Senate, many conscientious doctors are wondering what attitude to take to a social measure to which they are opposed. So far the AMA, which led the fight against Medicare, has offered no guide, and many physicians are adopting a wait-and-see attitude before deciding what they will do.

Unfortunately, some doctors seem to have decided that if they can't make the rules, they aren't going to play ball. The State Medical Associations of Ohio, Texas, Arizona, Louisiana and Florida, as well as a number of county societies, have already formally resolved that their members should not participate in the Medicare program. While such resolutions reflect the zeal of these societies for the preservation of the present system of medical practice, the attitude of the doctors smacks more than a little of the poor loser, the spoiled child. It is difficult to see what non-participation in the Medicare program is going to accomplish. Certainly the only injured party can be the patient who needs the hospital care offered by Medicare. If the physician wants to treat the over-65 patient free of charge, it is to the glory of the physician. But what can be accomplished by attempting to deprive the patient of hospital care that is offered to him as a benefit of his United States citizenship and of his social security participation?

One of the organizations behind the movement is the Association of American Physicians and Surgeons, Inc., with headquarters in Chicago. The literature of this group speaks of the "ethical, moral, and legal ways of not participating in HR-6675," as though to do otherwise were unethical, immoral and illegal. It refers to those who may decide not to make fools of themselves as "appeasers." Their literature also promises that "The Association further seeks restoration of lost freedoms and the retention of the traditional liberties of all Americans. . . ." Those who have been exposed to it will recognize the ultra-conservative, "far-right" character of this kind of approach to a social problem.

The American Medical Association is the duly constituted, universally recognized, and generally effective voice of organized medicine. It has been the AMA that has carried on the fight against Medicare, and the fact that the measure has been delayed so long in the face of tremendously powerful and popular support is a tribute to its success. Even so, the AMA has never been known for its social liberalism, and the image of organized medicine has probably suffered because of its seeming resistance to social change. (For example, many people still believe that the AMA always opposed social security.) What organized medicine does not need is a splinter group of doubtful political affiliation to speak for it. Nothing but harm can come from an unreasonable, disorganized and disorganizing attempt at action taken too late, and misdirected from the start.

The Medicare crisis is a serious one for American medicine. It requires serious thought by responsible medical personnel. It challenges our wisdom and our social responsibility. Whatever action is taken should represent the consensus of American doctors. The course urged by the AAPS is surely not that consensus and will result only in further damage to the doctor-patient relationship.

It is to be hoped that no more medical societies are misled by the recommendation of the American Association of Physicians and Surgeons. And when the conscientious, patriotic doctor reads the literature of the AAPS, he may well wonder at the *real* purpose behind the typically stereotyped prose of this unusual organization which claims to speak for American medicine. —D.N.G.

LETTERS

VOLUNTARY STERILIZATION

To the EDITOR:

Time Magazine of January 15, 1965 in an article prepared and reviewed by preeminent medical and legal authorities, states: "Though neither doctors nor their patients like to talk about it, voluntary sterilization has become one of the most popular operations in the U.S. Statistics pile up behind a veil of silence, but best estimates are that 1,500,000 Americans have already been sterilized and 100,000 more are operated on each year."

The Association for Voluntary Sterilization, which maintains a nationwide roster of 1500 cooperating physicians, has held that voluntary sterilization is legal in all 50 states, with restrictions upon it in only three states—Connecticut, Kansas and Utah. It is interesting to note that when appropriate consent forms from the party or parties were obtained for a voluntary sterilization operation, there is no case on record where a physician has ever lost a suit.

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin, 53701.*

Therefore, we were amazed to read in the January, 1965 issue of the *Wisconsin Medical Journal* an article entitled "Medical Staff Rules and Regulations as to Sterilizations" in which an opinion was expressed that voluntary sterilization is not legal in Wisconsin.

I referred this matter to AVS Legal Counsel, Mrs. Harriet F. Pilpel, one of America's great legal authorities on law and family planning. I have received the following letter from her which I quote in full:

"We have studied the 'Medical Staff Rules and Regulations as to Sterilization' from the January, 1965 issue of the *Wisconsin Medical Journal.*

"We note the opinion of counsel for the State Medical Society to the effect that 'sterilization is tolerated by the law only if it benefits the health of the patient on whom the surgery is performed.'

"As we understand the reasoning behind this conclusion, it is to the effect that Section 46.12 of the Wisconsin Statutes, which provides for the sterilization of criminal, mentally ill and mentally deficient persons who are inmates of State and County Institutions, has the effect of prohibiting voluntary

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sterilization of persons who do not fit this category or who are not confined to such institutions, unless the operation is performed for the benefit of the health of the patient, regardless of the consent of the patient.

"So far as we know, in no other state has the presence on the statute books of an involuntary sterilization law been held to bar voluntary sterilization, where the person to be sterilized is an adult and consents to the operation, nor do we know of any court decisions in any state reaching this result. Of course, in Connecticut, Kansas and Utah there are explicit statutory limitations on voluntary sterilization but that is not the situation in Wisconsin.

"The reasoning behind the opinion here at issue apparently is that in the absence of statute, sterilization for 'non-therapeutic' reasons would be considered mayhem.

"While we are aware of the fact that there are opinions of the Attorney General in Wisconsin which discuss the possibility that such operations could be considered mayhem, we note the following:

a) We know of no court decision in Wisconsin or any other state which so holds.

b) The leading case in this area, i.e., the case of *Christensen v. Thornby*, contains a definite statement on the part of the highest court of Minnesota to the contrary.

c) The existence in Wisconsin and a number of other states of laws permitting compulsory sterilization of certain classes of people would strongly suggest that this operation is not considered mayhem, since the effect of these laws is to sanction or command such procedures in most states, wholly irrespective of the consent or of the health of the patient and, of course, in no sense for punitive or deterrent purposes within the ordinary contemplation of criminal law. It is hardly to be assumed that the legislatures in all of these jurisdictions have intended to authorize mayhem upon the bodies of persons confined in state institutions, or that the U.S. Supreme Court in upholding the constitutionality of such legislation in *Buck v. Bell*, considered such an operation to fall into this category.

d) It should also be noted that, in 1963, the state of Virginia enacted a law outlining procedures for voluntary sterilization when both spouses consent. This again is inconsistent with an assumption that voluntary sterilization falls within the area of mayhem.

e) We have studied the opinions of the Attorney Generals of Wisconsin referred to. We do not construe them as reaching the result suggested by counsel to the State Medical Society. In the first place, it should be noted that according to advice we have received from Wisconsin counsel, opinions of the Attorney General do not have the force of law. They are entitled, in certain circumstances, to 'considerable weight' but this appears to relate to circumstances in which the legislature has acted, or deliberately failed to act, in such a way as implicitly to embrace the Attorney General's opinion. We do not understand this to have been the case with respect to the opinions in question.

"In any event, as we read the most recent opinion of the Attorney General, i.e., that of June 25, 1938, it stands only for the proposition that sterilization may be performed where it 'would benefit the patient's health' and is by no means a clear opinion to the effect that in other instances the operation is illegal. Similarly, the opinion of October 12, 1932 does not conclude that the operation is illegal but rather suggests the possibility that a court might so find, from which it is suggested that caution on the part of physicians would be prudent.

"It is interesting to note that the Law Department of the American Medical Association, in its publication called 'Medicolegal Forms with Legal Analysis,' 1961, states at page 28 with respect to states other than Connecticut, Kansas and Utah, (in which the permissible scope of sterilization other than compulsory sterilization of defectives is specifically defined by statute) that 'until declared illegal by the legislature or the courts in the physician's state, non-therapeutic sterilization is largely a matter of individual conscience and liberty. With regard to civil damages, sterilization does not present any greater exposure to liability than any other medical and surgical procedures alleged to have been negligently performed.' This discussion also indicates the view of the AMA that only in Connecticut, Kansas and Utah is it criminal to perform a sterilization operation 'without therapeutic or eugenical justification.'

"Recent court opinions in cases in California, Pennsylvania and Minnesota also indicate that voluntary sterilization is not contrary to public policy.

"In the absence, therefore, of any legislation or court decisions in the State of Wisconsin, we cannot agree with the conclusion that there is basis for declaring that voluntary sterilization of competent adults is contrary to public policy or otherwise illegal.

Very truly yours,
GREENBAUM, WOLFF & ERNST
By: Harriet F. Pilpel"

In the interests of providing Wisconsin physicians with the facts regarding "one of the most popular operations in the U.S." I sincerely hope that you will publish my letter in full.

H. Curtis Wood, Jr., M.D., Medical Field Consultant, Association for Voluntary Sterilization, Inc., 515 Madison Avenue, New York, N. Y. 10022, welcomes inquiries from Wisconsin physicians. Dr. Wood is available to speak before State and local medical and hospital groups.

JOHN R. RAGUE
Executive Director
Association for Voluntary Sterilization, Inc.
515 Madison Avenue
New York, N.Y. 10022

the wisconsin medical journal

SPECIAL ISSUE: PEDIATRICS

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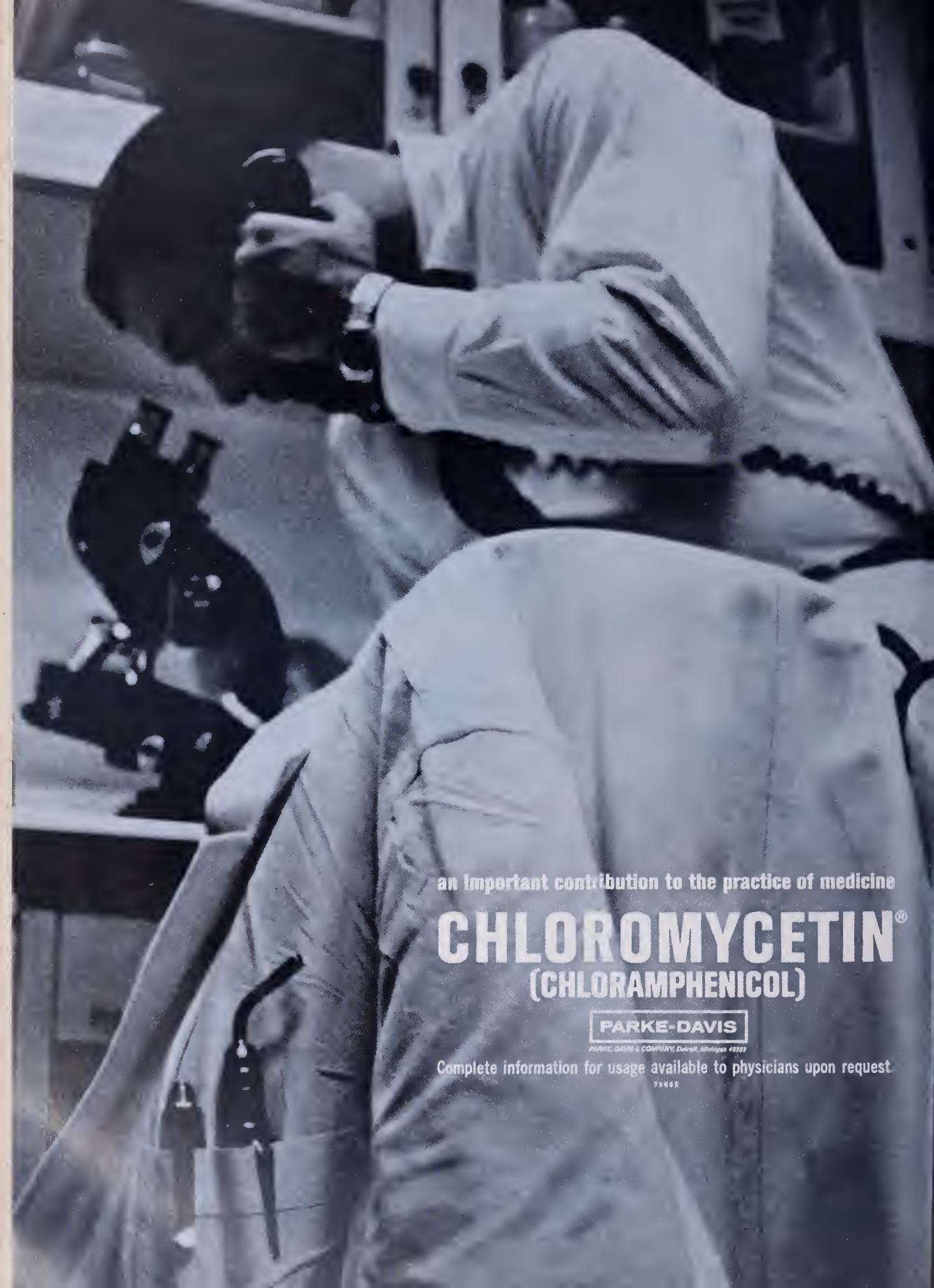
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COUNTY SOCIETY PROCEEDINGS

BROWN

Drs. Robert Brault and *Stuart Milson* were elected to permanent membership in the Brown County Medical Society during the business session of the organization's meeting May 20 in Green Bay.

Dr. R. M. Waldkirch, Society president, reported that *Dr. R. A. Gruesen* had twice been subpoenaed in recent weeks for testimony in regard to cases. *Dr. Arthur J. McCarey's* committee was requested to investigate the situation and see what could be done to ameliorate it.

Reports were heard from delegates to sessions of the House of Delegates at the State Medical Society annual meeting in May.

Following dinner, the 43 doctors present heard a discussion by Dr. Robert McCollough of the investigation of the cluster cases of leukemia in Green Bay undertaken by the National Institute of Health. Doctor McCollough is epidemic intelligence service officer of the NIH.

DANE

At their last meeting until September, held June 8 at State Medical Society headquarters, members of the Dane County Medical Society heard a talk by *Dr. Margaret Prouty* on "Mountain Climbing in Nepal."

During the months of March and April of this year, Doctor Prouty completed the first commercial venture to the base of Mount Everest at the Nepal–Tibet border. Her talk included a demonstration of some of the equipment necessary for mountain climbing expeditions, and a discussion of the geography and people of Nepal and notable events of the trip. These included tea and dinner with the High Lama of Thyangboche, second in command to the Dali-Lama of Tibet, and a meeting with the Indian expedition which had recently completed a successful assault upon Mount Everest.

New members of the Society are *Drs. Russell C. Briggs, David G. Bryant,* and *Kenneth O. Loken.* Born in Montpelier, Vt., Doctor Briggs received his medical degree from Albany Medical College in 1958, served his internship at Albany Hospital, Albany, N. Y., and completed resident training in radiology at the University of Vermont. He is currently a postdoctoral fellow in radiation therapy at University Hospitals.

Also at University Hospitals is Doctor Bryant, who is in his fourth year of orthopedic surgery residency. A native of Middletown, O., Doctor Bryant graduated from New York Medical College in 1960 and served his internship at St. Luke's Hospital at Cleveland, O.

Doctor Loken was born at Lancaster and attended the University of Wisconsin Medical School, where he received his M.D. degree in 1961. He completed his internship at Madison General Hospital, where he is currently a resident in pathology.

The Society's next meeting will be the annual golf tournament in September.

DODGE

A majority of the members, and their wives, were present for the June 3 meeting of the Dodge County Medical Society at the Pyramid Supper Club, Beaver Dam.

Speakers were two Madisonians, P. R. Smith, whose subject was "Estate Planning and Wills," and D. F. Bowman, who discussed "Investments." A 50-minute question and answer period followed.

At the meeting on April 29, the Society offered its congratulations to *Dr. O. F. Goetsch* on becoming a life member of the State Medical Society.

GREEN LAKE–WAUSHARA

Wives were included at the meeting of Green Lake–Waushara County Medical Society June 24 at Scharenberg's White Lake Resort near Montello, and the speaker, *Dr. Frank D. Bernard* of Madison, made his talk on plastic surgery especially interesting for them.

Welcomed as a new member was *Dr. S. L. Hadden*, Wild Rose, who practiced in Live Oak, Fla., for nine years.

The Society's next meeting is slated for September in Berlin.

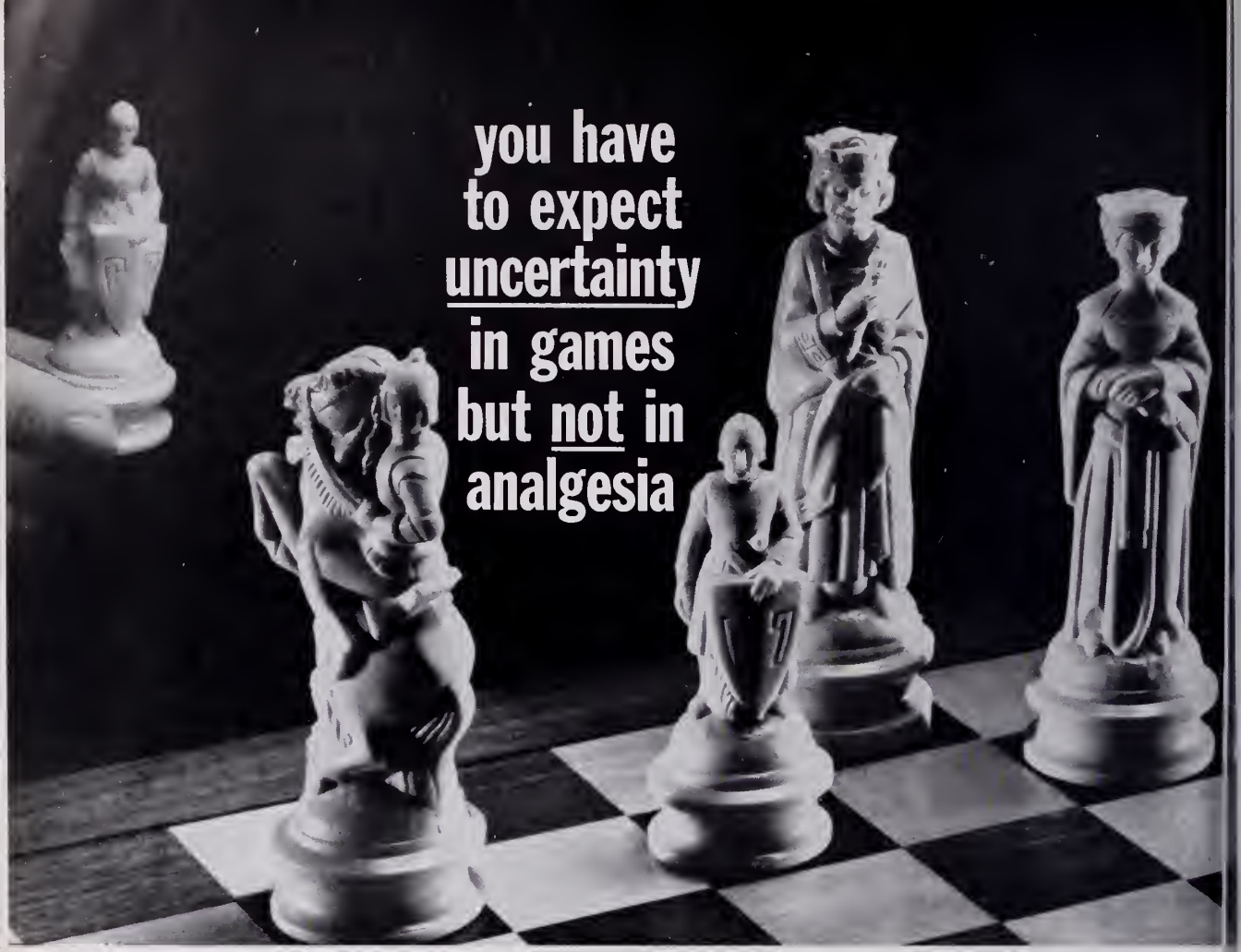
PORTAGE

The practice of medicine in Portage County yesterday, today, and in the future was discussed at a meeting of the Portage County Medical Society held June 17 at the Hot Fish Shop in Stevens Point. Comments by various members were heard during the discussion period, which was planned in the hope that out of an awareness of the past, present, and future, a constructive program will emerge to keep medicine moving in a progressive direction in Portage County.

WAUKESHA

The Waukesha Daily Freeman quoted *Dr. Thomas E. Dugan*, Waukesha, Society president, as saying that there was no indication of a doctors' rebellion or a boycott against medicare at the June 2 meeting of the Waukesha County Medical Society. The meeting took place at Oakton Manor, Pewaukee.

Physicians whose names appear in italics are members of the State Medical Society.



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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Occupational Therapy Association

Approximately a hundred occupational therapists and other persons concerned with the care of patients in nursing homes and long-term care facilities gathered at the Schroeder Hotel, Milwaukee, June 14–16 for an Institute sponsored by the Wisconsin Occupational Therapy Association and the Wisconsin State Board of Health.

As keynote speaker, Dr. Constantine Panagis said that a new approach is needed to restore aged and chronically ill patients to active lives. "Diseases have been conquered and lives have been extended and saved, but all too often we save the life of an individual only to leave him impaired or disabled. This can oftentimes be more tragic than death itself," said Doctor Panagis, who is director of the chronic illness program at the Milwaukee County Institutions.

Dr. Frederick Blancke, director of medical geriatric service at Mendota State Hospital, Madison, said in an interview that the difficulty with aged people is, first, there are so many of them, and, second, they are a very quiet group who don't speak up for themselves and are quite neglected. With the help of a federal grant, Doctor Blancke said, a mental health revolution is taking place in state hospitals.

Dodge County Medical Assistants

The Dodge County Medical Assistants Society presented an electric kiln and materials for ceramic and enameling projects to the Retarded Children Day Care Center education unit at Beaver Dam in June. Money for the project was raised at a benefit held several months prior to the presentation.

Sally La Fleur is president of the organization and Mrs. Marie Swain is chairman of its ways and means committee.

Wisconsin Chapter, AAIT

Inhalation Therapy's Part in a Small Hospital was the theme of the annual meeting of Wisconsin Chapter, American Association of Inhalation Therapists, June 5 at St. Claire's Hospital, Baraboo.

Physicians on the program and their topics were *Dr. Curtis Knight*, Department of Anesthesiology, University Hospitals, Madison, and *Dr. Carl W. Schmidt*, Department of Anesthesiology, Methodist Hospital, Madison, "Inhalation Therapy and Medical Gases;" and *Dr. Edgar End*, Marquette University School of Medicine, Milwaukee, "Hyperbaric Oxygenation and Its Advancements."

Among the other speakers was Terrill Johnson, A.R.I.T., president Wisconsin Chapter A.A.I.T., Green Bay.

Sheboygan County Unit, WHA

Drs. Donald M. Rowe of the Kohler Clinic and *Thomas C. Puchner*, Milwaukee cardiologist, were among the speakers for a "Cardiac in Industry" conference held early in June at Sheboygan under the sponsorship of Sheboygan County Unit of the Wisconsin Heart Association.

Doctor Rowe described the heart detection program established about ten years ago at the Kohler Company when that industry became aware of the high prevalence of heart disease among industrial workers. He keynoted the problem of cardiacs in industry when he pointed out that a survey of 18 large corporations showed a total of six million heart attacks during a single year.

Speaking on the subject, "Can Heart Disease Be Prevented?", Doctor Puchner listed the two major factors involved as constitutional and environmental.

Conference moderator was Vincent Meyer, administrative director of the Sheboygan Clinic and outgoing chairman of the Sheboygan unit.

During the week preceding the conference, Mr. Meyer presented a paperweight plaque to Howard A. Farrey for his leadership of the 1965 Sheboygan Heart Fund Drive. Mr. Farrey was also appointed the new chairman of the Sheboygan County Unit, to serve for the fiscal year which started July 1.

At the same meeting, an identical plaque was presented to Eldred L. Johnson for his efforts in conducting the county campaign. Association officers also cited eight officials of the recent drive who will receive "heart pins" for their excellent work on behalf of the organization. Among the eight is *Dr. Robert M. Senty*, physician chairman.

State Medical Assistants Society

"Passport to Progress" was the theme of the tenth annual meeting of the Wisconsin State Medical Assistants Society June 4–6 at the Coach House Motor Inn, Milwaukee.

The Wisconsin Physicians Service sponsored a noon luncheon Friday before the State Medical Society House of Delegates convened. General sessions were held Saturday morning. Speakers were Gordon L. Peckham, curator of the Museum of Medical Progress and Stovall Hall of Health, Prairie du Chien, and *Dr. William B. Gallagher* of La Crosse, whose subject was "Project Hope in Peru."

County chapter presidents were honored at the Saturday luncheon. Afternoon speakers were Dr. Daniel C. Braun, assistant medical director of the U. S. Steel Corporation, who spoke on "Training is Always," and Raymond H. Meyer of the University of Wisconsin–Milwaukee, whose topic was "Formula

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Physicians whose names appear in italics are members of the State Medical Society.

for a Successful Meeting." Frank X. Dance, Ph.D., also of the University of Wisconsin–Milwaukee faculty, spoke Saturday evening on the topic "The Medical Assistant—Future and Fortune."

Miss Alice Roelse of Port Washington was installed as WSMAS president for the coming year in a candlelight ceremony conducted by Miss Alice Bundy, Milwaukee, a past president of the 512-member association. Other officers elected and installed were Mrs. Vera Erdman, Appleton, president-elect; Mrs. Esther Cooper, Beloit, recording secretary, and Mrs. Margaret Russell, Waukesha, treasurer.

Delegates elected to attend the national convention in New York City next October were Mrs. Peggy Gallagher, Waukesha; Miss Edith Murphy, Milwaukee; Miss Roelse and Mrs. Erdman.

WHA Clinics

Sixteen patients were examined at the congenital and rheumatic heart disease clinic conducted by the Wisconsin Heart Association in June at Memorial Hospital, Manitowoc. *Dr. Philip A. Zlatnik* of Two Rivers scheduled the patients, who were referred by local physicians, and examinations were conducted by two Milwaukee specialists, *Dr. John H. Huston*, cardiologist, and *Dr. Sherburne F. Morgan*, pediatrician. The clinic was held with the approval of the Manitowoc County Medical Society.

The Door–Kewaunee County Medical Society cooperated with the WHA in conducting the clinic held somewhat earlier at Algoma Memorial Hospital, Algoma. Doctor Morgan and *Dr. William L. Coffey, Jr.*, Milwaukee, were the examining physicians.

March of Dimes Grant To Finance UW Mental Retardation Research

A search at the University of Wisconsin Medical Center for a common genetic cause of certain forms of mental retardation and seemingly unrelated birth defects has begun under a new $36,443 grant from the National Foundation—March of Dimes.

Ben F. Prochaska, Madison, president of the Dane County March of Dimes, presented the check to Dr. John Opitz, assistant professor of pediatrics and medical genetics and acting director of the Medical Center's Birth Defect Center, which is supported by another National Foundation grant. Cooperating in the 18-month study with Doctor Opitz will be Klaus Patau, Ph.D., professor of medical genetics. The two have been concerned with those children who are mentally retarded and also have several defects, often of a minor nature.

Under the new grant, the two men will study the frequency with which the combination of birth defects and mental retardation could be due to chromosomal defects.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Sims Commands Unit

Dr. J. LeRoy Sims, colonel, commanded the 44th General Hospital, Madison area U.S. Army Reserve hospital unit, at its summer training in June at Fitzsimons General Hospital, Denver, Colo. It was the first time in 17 years that the unit had left for summer training under the command of someone other than *Dr. Herman H. Shapiro,* colonel, who retired last December after serving as its commanding officer since 1948. An advance detachment was under the command of *Dr. Bruce J. Longley,* lieutenant colonel, and the Sheboygan detachment was commanded by *Dr. Edward R. Loftus,* lieutenant colonel and a physician at Winnebago State Hospital.

Fond du Lac Doctors Move

Drs. H. J. Kief, N. O. Becker, W. E. Myers, and *J. U. Peters,* members of Associated Physicians of Fond du Lac, moved into a new medical building in Fond du Lac June 1. Office space for at least six physicians is included in the building, which was started last October. Associated Physicians of Fond du Lac is a successor to the Gavin Clinic, founded in the 1920's by the late Dr. S. E. Gavin.

Dr. Chandler Heads Appleton 'Y'

Dr. William W. Chandler was elected president of the Appleton YMCA May 27 and will head the organization as it takes over operation of its new building.

Dr. Liewen Certified

Dr. Benedict E. Liewen, Fond du Lac obstetrician and gynecologist, has been certified as a diplomate of the American Board of Obstetrics and Gynecology.

Dr. Zimmerman at Viroqua

Dr. Tim Zimmerman moved to Wisconsin in mid-July from the state of Washington to become resident physician for the Vernon County Hospital and the two associated homes at Viroqua. He was hired by the Vernon County Welfare Department. Doctor Zimmerman, who has a wife and three children, is associated with *Dr. P. T. Bland,* Westby.

Dr. Eisenman at Oconomowoc

Dr. Theodore S. Eisenman, 1964 graduate of the University of Illinois College of Medicine, joined the staff of the Wilkinson Clinic at Oconomowoc in mid July. In June, he completed a one-year internship at Milwaukee County General Hospital.

Dr. Lucas on Red Cross Board

Dr. Andrew Lucas, Wisconsin Rapids, was reelected a director of South Wood County Chapter, American Red Cross, at the chapter's annual meeting May 26 at Wisconsin Rapids.

Group Hears Dr. Gordon

Dr. Edgar S. Gordon, professor of medicine at the University of Wisconsin Medical School, gave a talk at the Milwaukee Vocational School in May under the sponsorship of the school and the Milwaukee Dietetic Association. Doctor Gordon explained why his reducing diet of six meals a day following a two-day fast was developed, and Mrs. Grace J. Chosy, assistant in dietetics at University Hospitals, who worked with him, talked about the diet and why certain foods were selected for it.

Dr. Custer Addresses Graduates

Dr. G. Stanley Custer, president of the Marshfield Clinic, was speaker for the 1965 commencement exercises at Columbus High School, Marshfield. "The world is not yours, you belong to the world and this is your challenge: Conquer yourselves," he told the graduates.

Dr. Glass at Two Rivers

Dr. David E. Glass joined *Drs. A. P. Zlatnik, S. L. Weld, S. L. Kaner,* and *Philip Zlatnik* on July 19 at Doctors Clinic, Two Rivers. Doctor Glass, who is a general practitioner, interned at St. Mary's Hospital, Duluth.

Dr. Fischer Joins Marshfield Clinic

Dr. Herbert K. J. Fischer, a physiatrist and a native of Germany where he received his medical education and degree at Eberhard Karl University, Tuebingen, has been added to the staff of the Marshfield Clinic in Marshfield.

Dr. Stone Leaving Berlin

Dr. Grant C. Stone, Berlin physician since 1939, closed his office and brought his medical practice in that city to an end July 1, with plans to travel west and vacation for a time before choosing another location to resume his practice.

Dr. Sun Serving Redgranite

Since early June, residents of the Redgranite area have enjoyed the services of *Dr. Kwoh Cheng Sun* on a regular weekly basis. Doctor Sun has been practicing in Wautoma since February 22.

Physicians whose names appear in italics are members of the State Medical Society.

Doctors Aid in School Program

Several Milwaukee area physicians were among the fathers who took time off from their busy schedules, toward the end of the school year, to explain some of their labors to an Indian Hill school second grade social studies class. Physicians who helped present the "Fathers as Helpers" program to the class were *Drs. A. S. Lieberthal, G. R. Zupnik*, Stanley Berlow, *H. F. Ibach, S. M. Barnett* and *Murray Herman*, and *Dr. Gale L. Mendeloff*, surgeon.

MICHIGAN STATE MEDICAL SOCIETY

Centennial Session

Sept. 19–24 **Detroit**

The Michigan State Medical Society has extended a personal invitation to members of the State Medical Society of Wisconsin to join them in celebration of a century of service in medicine. "Daily themes have been developed and each day will be a convention in itself, replete with scientific, professional, and social events," declares Oliver B. McGillicuddy, M.D., Lansing, president of the MSMS.

To show its warm and high regard for the neighboring society, the Council of the State Medical Society of Wisconsin, meeting in Madison August 1, adopted a resolution which follows:

WHEREAS, The voluntary association of physicians through the years has been a constant force in promoting the art and science of medicine and continually improving standards of medical education and medical practice devoted to the betterment of the health of the people; and

WHEREAS, The Michigan State Medical Society during 1965 is observing the 100th Anniversary of its founding, having designated its September 19–24 annual meeting as its Centennial Session; and

WHEREAS, The planned program of the Michigan State Medical Society's Centennial Session gives evidence of medicine's recognition and appreciation of other groups and agencies as allies in the total health care effort; and

WHEREAS, The State Medical Society of Wisconsin, having achieved and commemorated this most important milestone in 1941, recognizes fully the importance of such an historic occasion; therefore be it

Resolved, That the physicians of Wisconsin hereby extend sincere congratulations to the Michigan State Medical Society in this its Centennial Year; and be it further

Resolved, That the State Medical Society of Wisconsin pledges its continued best efforts to cooperate with the Michigan State Medical Society and other constituent units of the American Medical Association in striving to maintain the high ideals of the medical profession and in safeguarding the health interests of those whom we serve.

Following is the six-day plan: Sunday, Sept. 19—Medicine and Religion Day; Medicine and Business, Industry and Communications Day; Tuesday, Medicine and Medical Organization Day; Wednesday, Medicine and Science Day; Thursday, Medicine and Voluntary Health Day; and Friday, Medicine and Government Day.

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PHYSICIAN NEWS *continued*

his internship at the Tucson Medical Center, Tucson, Ariz. He received his medical degree in 1964 from the University of Louisville, Louisville, Ky.

Dr. Tenney Medical Director

Dr. Horace Kent Tenney III, assistant professor of pediatrics at the University of Wisconsin Medical School, Madison, on July 1 assumed the position of medical director for the Bureau for Handicapped Children, State Department of Public Instruction. He replaced *Dr. Patricia McIllece*, who is returning to school to study on a fellowship.

Doctor Tenney has his bachelor's (1943), his master's (1945), and his medical (1946) degrees all from Northwestern University. He served his internship in the U.S. Navy Hospital at Newport, R.I., and his residency in pediatrics at Children's Hospital in Denver, Colo. Since 1959 he has been assistant professor, Pediatrics at the University of Wisconsin Medical School.

Doctor Tenney also carried on private practice in Madison from 1950–1959, was attending pediatrician at Morningside Sanitarium in 1955 and director of the Poison Information Center in 1960. He served in the U. S. Navy from 1946–1948.

Drs. Gundersen, Schuldes Certified

Two physicians at Gundersen Clinic, Ltd., La Crosse, have recently been certified by the boards in their respective specialties. *Dr. Rudolf E. Schuldes* has been notified that he has been certified by the American Board of Obstetrics and Gynecology, and Dr. A. Erik Gundersen has been notified of his certification by the American Board of Surgery.

Drs. Raschbacher, Thorgersen Promoted

Dr. J. L. Raschbacher was elected secretary of the Waukesha Memorial Hospital medical staff in June to fill the vacancy created when *Dr. H. A. Settlage* moved. *Dr. Thor Thorgersen* was transferred from temporary to assistant staff in the pathology department.

New Professors at UW

Dr. Jack C. Westman was appointed in June as professor of psychiatry at the University of Wisconsin Medical School, Madison. He was formerly associate professor of psychiatry at the University of Michigan, Ann Arbor, where he received his M.D. degree in 1952 and an M.S. in psychiatry in 1959. Since 1958 he had occupied positions of increasing responsibility at Michigan, beginning as instructor.

Recently appointed assistant professor of psychiatry at the Medical School is Dr. William M. Bolman, a graduate of Harvard Medical School who has been an assistant in psychiatry at Massachusetts Memo-

rial Hospital and a clinical assistant in pediatric psychiatry at Boston City Hospital.

Drs. Gordon, Vermund on NIH Committees

Dr. Edgar S. Gordon, professor of medicine at the University of Wisconsin Medical School, has been invited to serve as a member of the Arthritis and Metabolic Diseases Program Project Committee of the National Institute of Health. His term began July 1 and ends June 30, 1969.

Dr. Halvor Vermund, director of the University Radiotherapy Center, assumed his duties July 1 as a member of the NIH Radiation Study Section.

Dr. Bloodworth Presents Papers

Dr. J. M. B. Bloodworth, Jr., professor of pathology at the University of Wisconsin Medical School, presented a paper, "Ultrastructural Demonstration of Basic Similarities Between Human Diabetic Glomerulosclerosis, Glomerulonephritis, and Systemic Lupus Erythematosus" at a meeting of the American Diabetes Association June 19 in New York. Some time earlier, he presented a paper on "Ultrastructural Aspects of Human and Canine Diabetic Retinopathy" at a symposium on vascular disorders of the eye in San Francisco.

Dr. Cameron Attends Meetings

John R. Cameron, Ph.D., attended an international conference on luminescence dosimetry in June at Stanford University in California. Earlier that month, he attended a meeting of the board of directors of the Society of Nuclear Medicine in Miami. He is the only Society member from the University of Wisconsin, Madison.

Dr. Holford Retires

Dr. Frances E. Holford, associate professor of medical microbiology, retired in June after 45 years of association with the University of Wisconsin, Madison.

Advisory Committee Elections

Donald W. Smith, Ph.D., associate professor of medical microbiology at the University of Wisconsin Medical School, has been elected pre-clinical member of the faculty advisory committee. *Dr. Karl Siebecker, Jr.*, professor of anesthesiology, has been elected to the clinical position. The two, who began their three-year terms July 1, replace *Dr. John Juhl* and Harold Deutsch, Ph.D.

State Medical Society Council Award Presented to Dr. Beebe of Sparta

A Sparta physician who has become the symbol of the country doctor in Wisconsin was honored June 9 when the State Medical Society of Wisconsin presented the Council Award to *Dr. Spencer D. Beebe.*

THE COUNCIL AWARD, highest honor the State Medical Society bestows, was presented to Dr. Spencer D. Beebe (center) June 9 in a ceremony held at the Sparta home of his son, Dr. DeWitt C. Beebe. Dr. James C. Fox (left), Council chairman, made the presentation. At the right is Dr. J. H. Haughton of Wisconsin Dells, Society president, one of several distinguished guests at the occasion.

In making the presentation, *Dr. James C. Fox*, La Crosse, Council chairman, pointed out that it is made only to those who have served the science of medicine, their fellow physicians, and the public with outstanding distinction.

"The greatness, yet the honest simplicity of this physician is felt throughout the state," Doctor Fox said. "From horse and buggy to space medicine, a period not equalled in any other time of scientific medicine, this man has stood for his ideals, has been recognized for his loyalty, and is revered by his acquaintances."

At age 95, Doctor Beebe is one of the oldest physicians in the state. In retirement now, he is a resident of the Monroe County Infirmary, where he served for many years as physician, a position assumed by his son, *Dr. DeWitt C. Beebe*, at whose home in Sparta the presentation ceremony was held. He returns often to his home in Sparta, visits with his friends, and keeps abreast of happenings at St. Mary's Hospital, where he served throughout his practice. A native of Sparta, he received his medical training in Chicago and practiced briefly in Aurora, Ill., and Elroy before returning to his home community, where he served for more than 60 years.

When he was 90, he commented, "I've had every honor that any man could ever hope for . . ." These included selection as "Wisconsin Country Practitioner of 1950," a 1953 observance in honor of his 50 years of practice in Sparta, honorary recognition by the Wisconsin Council of Agriculture Cooperatives, and, now the Council Award.

Members of the doctor's family and all Monroe County physicians and their wives were among the numerous guests at a reception held following the presentation.

Drs. Golden, Hobbins Elected

Dr. Peter B. Golden was elected vice-president of the Madison General Hospital Medical and Surgical Foundation at its annual meeting in June. *Dr. Wil-*

liam B. Hobbins was elected secretary–treasurer. Frederick Mackie was named a director of the foundation to fill the unexpired term of *Dr. R. T. Cooksey*, (since deceased) founder of the organization, who was awarded an honorary life membership in "deep appreciation of his work the past eight years in the foundation."

Ephraim Honors Dr. Sneeberger

Dr. William A. Sneeberger, 79, who has practiced at Ephraim since 1921, was honored as Viking Chieftain of the 1965 Fyr Bal festival at Ephraim in June. Doctor Sneeberger, who can recall the days when he made winter house calls in horse and cutter, practiced in Orfordville and Racine before coming to Ephraim. He took his medical training at the University of Wisconsin and Rush Medical School, Chicago.

New Clinic Opens at Green Bay

The new Beaumont Clinic opened in June at Green Bay. It is named after Dr. William Beaumont, who was in Green Bay from 1826 to 1828 while he served as an Army contract surgeon at Fort Howard.

The clinic consists of four departments staffed by ten Green Bay physicians: *Drs. R. G. Wochos* and *K. L. Zucker*, surgery; *T. R. Leicht* and *J. H. Randall*, internal medicine; *S. D. Austin* and *H. F. Sandmire*, obstetrics and gynecology; and *R. L. Myers, D. W. Shea, S. L. Griggs*, and *K. C. Mickle*, pediatrics.

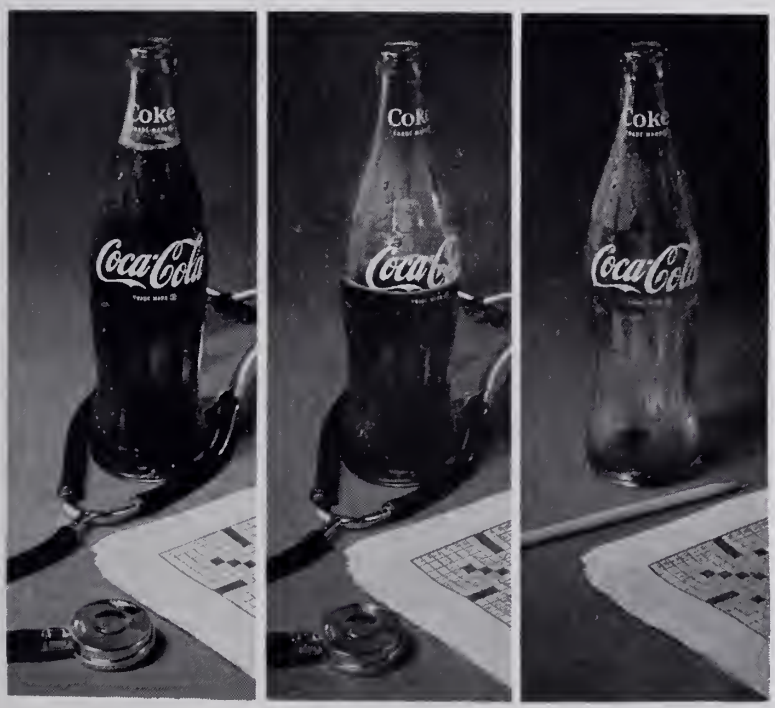
Service in Haiti Recounted

Dr. and Mrs. *Wilson Troup's* month of service in Port de Paix was the subject of a full-page feature article in the June 20 GREEN BAY PRESS–GAZETTE. Illustrated in color, the story recounted the couple's experiences on their "busman's holiday in humanity's behalf" in April in the Caribbean Republic community of nearly 8,000.

Although she hadn't planned to, Mrs. Troup assisted her husband during his month of service as a physician for Focus, Inc., whose program he heard of last October at a meeting of the American Academy of Ophthalmology. Founded by Dr. James E. McDonald of Chicago, Focus stands for Foreign Ophthalmological Care in the United States. The clinic was inaugurated in January 1962 following completion of negotiations with the Haitian government.

Dr. Janowiak with Ravn Clinic

Dr. James S. Janowiak has joined *Drs. E. O. Ravn, Sr.*, and *E. O. Ravn, Jr.*, in the practice of medicine, obstetrics, and surgery at Merrill. A 1961 graduate of Marquette University School of Medicine, Doctor Janowiak interned at St. Mary's Hos-



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pital in Duluth and during the three years prior to his arrival in Merrill was in general practice in Waterville, Wash.

Dr. Rupel Speaks

Dr. John W. Rupel, obstetrician and gynecologist at the Marshfield Clinic, was the main speaker June 17 at the meeting of the Advisory Board of Catholic Social Service, Inc., of Marshfield. His topic was "Medical Evaluation of Adoptive Parents and Related Subjects." The meeting was conducted by *Dr. Gerald E. Porter*, president.

Dr. Ellison AMA Section Chairman

Dr. Edwin H. Ellison, professor and chairman of the Department of Surgery at Marquette University School of Medicine and director of surgery at Milwaukee County General Hospital, was elected chairman of the American Medical Association's Section on General Surgery during the annual AMA meeting in June in New York.

Marquette Faculty Appointments

The following appointments have been announced by *Dr. Gerald A. Kerrigan*, dean of Marquette University School of Medicine, Milwaukee:

Dr. Thomas T. Tang, assistant professor, Department of Pathology; Dr. Harold I. Dobbs, instructor, Drs. June Milne Dobbs and Sergio Andres de Lamerens, assistant professors, Department of Pediatrics; *Dr. Paul H. Goldstein*, clinical instructor, Ophthalmology; Dr. William C. Matousek, assistant professor, Department of Medicine, and *Dr. Paul J. Pitlyk*, clinical instructor, Department of Neurosurgery.

Dr. Milson Elected to Society

Dr. Bertram Milson, surgeon at Beacon Medical Center, Green Bay, has been elected to membership in the Wisconsin Surgical Society. Doctor Milson has been associated with the Milson–Sullivan Clinic for the past four years.

Dr. Koeller Aids

A tetanus immunization clinic for personnel of the Chippewa Lumber Industry, Inc., was held June 29 at Glidden. *Dr. A. A. Koeller* of Ashland administered the treatment.

Dr. Potts Honored

A Sheboygan native, Dr. Willis J. Potts of Sarasota, Fla., was honored June 6 when the Congenital Heart Disease Research and Training Center of Hektoen Institute, Chicago, was renamed and rededicated for him.

Doctor Potts, who retired early this year as surgeon-in-chief of Children's Memorial Hospital,

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Chicago, has been responsible over the past 20 years for saving the lives of thousands of babies born with heart defects. June 2, he was the central figure at a testimonial dinner, reuniting him and his "kids," sponsored by the Chicago Heart Association women's council at the Sheraton–Blackstone Hotel.

The Chicago Heart Association took advantage of the occasion to announce the establishment of the Willis J. Potts Foundation for Pediatric Cardiology, Pathology, and Surgery.

Doctor Potts and a colleague, Dr. Sidney Smith, perfected the operation which, since its first successful performance in 1946, has saved the lives of thousands of blue babies. Doctor Potts is also credited with inventing and perfecting an aorta clamp used in cardiac surgery.

Dr. Dudenhoefer Elected

Dr. Paul A. Dudenhoefer, Milwaukee, has been elected the first president of the Mid-America Society of Physical Medicine and Rehabilitation, formerly the Chicago Society of Physical Medicine and Rehabilitation. The organization also established two separate divisions, one each for Wisconsin and Illinois.

In the past, many physiatrists in Wisconsin have belonged to the Chicago Society. Now, as members of the Wisconsin Division, Mid-America Society of P.M.&R., they will have more local organization and recognition. The new name has come after several years of planning and study.

Also instrumental in the change, along with Doctor Dudenhoefer, was *Dr. Robert W. Boyle,* chairman of the by-laws committee.

Dr. Weston at Baraboo

After nine years of active duty, *Dr. Eugene L. Weston* has resigned as chief of Surgical Services, United States Air Force Academy Hospital, Colorado, to enter private practice as a general, thoracic, and peripheral vascular surgeon with Medical Associates, Baraboo. He has been located at Baraboo since July 1. A new clinic suitable for five physicians will be completed November 1 adjacent to the new St. Claire's Hospital. It will be initially occupied by Doctor Weston and *Drs. John T. Siebert* and *G. J. Holmen.*

In 1959–1960 Doctor Weston was chief resident in surgery at University Hospitals, Madison. He is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons.

Dr. Kersting Appointed

Dr. David W. Kersting, professor and chairman of the Department of Dermatology, Marquette University, School of Medicine, Milwaukee, has been appointed consultant in dermatology and director of the Marcus R. Caro Laboratory for Cutaneous

MEDICAL STAFF

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JOHN J. O'HARA, M. D.
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Doctor Kersting has recently participated in several scientific meetings. In Houston, he gave a series of lectures on sweat gland tumors and autogenous cutaneous exanthems at the University of Texas, M. D. Anderson Hospital. At the 84th annual meeting of the American Dermatological Association held in Maui, Hawaii, he presented a paper on the Chediak–Higashi Syndrome.

At the annual meeting of the Association of American Professors of Dermatology held in Chicago, he conducted a seminar on undergraduate teaching in dermatology. In addition, Doctor Kersting presented a paper on mycosis fungoides at the annual meeting of the American Academy of Dermatology, Chicago, and a paper on bullous dermatoses at the annual Jackson Clinic–Marquette University Postgraduate Seminar in Madison.

Dr. Wardlaw Appointed

Dr. E. H. Jorris, Wisconsin state health officer, has appointed Dr. James L. Wardlaw, Jr., to the position of assistant state health officer. The appointment was effective July 1.

Doctor Wardlaw joined the staff of the State Board of Health in January 1961 as director of the section on community health services. He had been director of the Monroe County Health Department at Key West, and had served with the Florida State Board of Health for 11 years. Doctor Wardlaw has an M.D. degree from New York University and a master's degree in public health from the University of North Carolina. He is a diplomate of the American Board of Preventive Medicine and a fellow of the American Puhlic Health Association.

In June at the organization's annual meeting in Madison, Doctor Wardlaw was named president-elect of the Wisconsin Public Health Association. He will take office as president next year. Karl A. Mohr, Green Bay deputy health commissioner, is the new president of the association succeeding Ione Rowley, Madison, president of the Wisconsin State Board of Nursing.

UW Professors Give Lectures

Six nationally known physicians on the faculty of the University of Wisconsin Medical School have presented lectures during the past several weeks in Madison.

The lecturers, their topics, and dates were:

Dr. Charles C. Lobeck, associate professor and chairman, Department of Pediatrics, "Pediatrics in a Changing Medical World," July 6; *Dr. D. Murray Angevine,* professor and chairman, Department of Pathology, "Behind the Scenes in Medicine," July 13; Dr. Harold P. Rusch, professor and chairman,

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Department of Oncology, "Current Trends in Cancer Research," July 20; *Dr. Robert C. Hickey*, professor and chairman, Department of Surgery, "Surgery at Mid-Century," July 27; Dr. Milton H. Miller, professor and chairman, Department of Psychiatry, "Where Is Psychology Going?", August 3; and *Dr. John Rankin*, professor of medicine, "Medicine and the Future of Modern Man," August 10.

Two New Doctors at St. Croix Clinic

Since July 6, Drs. Evan H. Peterson, Jr., and Glenn H. Koepke have been associated with the St. Croix Falls Clinic. Both received their M.D. degrees in 1964, Doctor Peterson from the University of Minnesota School of Medicine in Minneapolis and Doctor Koepke from the University of Colorado School of Medicine at Denver, and both interned for a year at Hennepin County General Hospital, Minneapolis.

Milwaukee Seminar of Physicians, Clergy Explores Need for More Cooperation

A seminar to explore the need for more cooperation between physicians and clergymen was held at Milwaukee in May under the sponsorship of 15 medical and pastoral organizations. Featured speaker was the Rev. Paul B. McCleave, LL.D., Chicago, director of the Department of Medicine and Religion of the American Medical Association, who emphasized the moral problems new discoveries have created in his address on "Two Forces—One Goal."

Workshops were held on the subjects, "Physician and Clergy in Terminal Illness," with *Drs. Alan B. Fidler* and *Edward S. Friedrichs* participating; and "Clarifying the Role of the Clergy and Physician in: the Community, the Hospital, and Mass Casualty Situations," with *Drs. Donald C. Ausman* and *J. J. Mueller* among the participants. Representatives of The Medical Society of Milwaukee County were among the panelists for a third workshop, on the topic, "Understanding Medical and Hospital Costs."

WPWA Hears Dr. Lawton

Dr. Ben R. Lawton, chief of surgery at the Marshfield Clinic, was among the speakers at the meeting of the Wisconsin Public Welfare Association in June at the Eagle Waters resort, Eagle River. Medical advances have created a vacuum which welfare workers must fill, he told the group.

Dr. Tierney Paid Tribute

Dr. E. F. Tierney, veteran Portage physician, was honored in June by the Portage city council. Tribute was paid him in the form of a special resolution citing his 34 years of unselfish service to the community as a member of the Portage library board.

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OBITUARIES

Dr. Leander P. Stamm, 71, died May 8, 1965.

A native of Milwaukee, Doctor Stamm was educated in that city, receiving his medical degree in 1916 from Marquette University School of Medicine and serving his internship from 1916 to 1917 at Milwaukee County Hospital. In World War I, he served in the Medical Corps of the U.S. Navy, rising to the rank of lieutenant commander. He then returned to Milwaukee and opened a practice in 1920.

Doctor Stamm served on the staffs of three Milwaukee hospitals: St. Joseph's, St. Michael's, and Milwaukee County, and he had also been a school physician for the Milwaukee Health Department.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Lillian A.; four children, John E. Stamm, Mrs. Fred Harris, Mrs. Robert L. Roberts, and Mrs. James G. Manschot; and 13 grandchildren.

Dr. Ernest O. Ronneburger, Milwaukee, died May 8, 1965, at the age of 57.

Born in Milwaukee and a 1932 graduate of Marquette University School of Medicine, Doctor Ronneburger interned at Milwaukee County General Hospital and then entered general practice at Cambria. After 10 years in that community, he received a commission as lieutenant (senior grade) in the Medical Corps, U.S. Naval Reserve, and saw active duty with an LST group which took part in the initial invasions of Sicily, the landings at Salerno, and later the Normandy invasion. There he was on the beach for three days during full-scale attacks which began on D-Day (June 6, 1944). From then on he made 50 Channel crossings until his relief came and he returned to the States for duty at the U.S. Naval Air Facility at Columbus, Ohio. He was discharged with the rank of lieutenant commander on May 15, 1946, and entered service with the Adjudication Division of the Veterans Administration at Milwaukee.

Surviving is his widow, Tesse L.

Dr. Philip D. Christensen, 40, well known Green Bay dermatologist, died May 11, 1965, in Green Bay.

He was born in St. Paul, Minn., June 30, 1924, and received his doctor of medicine degree from the University of Minnesota at Minneapolis in 1951. His internship was served at Emanuel Hospital, Portland, Ore. After practicing briefly at Watertown, Minn., he entered the U.S. Army Medical Corps in November 1951 and saw active service as a lieutenant in the Korean War. He was also a veteran of service in World War II, when he was a radar technician in the Navy from January 1945 to July 1946. Following his discharge in September 1953 from Korean War service, Doctor Christensen served a residency at University of Minnesota Hospitals. He had practiced in Green Bay since 1956.

He was a member of the Brown County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Minnesota Dermatological Society, and the Wisconsin Dermatological Society, a fellow of the American Academy of Dermatology, and consultant to the Veterans Hospital, Iron Mountain, Mich.

Survivors include his widow, Jeanne; three sons, Mark, Paul, and Matt, and one daughter, Jan, all at home.

Dr. Maurice Olsen, 67, Milwaukee physician, died May 15, 1965.

A native of Milwaukee, he was a graduate of Marquette University School of Medicine and interned at Misericordia and Trinity Hospitals, Milwaukee. He had practiced in Milwaukee throughout his career.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Grace; four daughters, Dr. Beverly Olsen Schumacher, Salem, Ore., Mrs. Gloria Metzer, Mrs. Valerie Huhnke, Milwaukee, and Cheryl, Lakeland College, Plymouth; and two sons, Richard M., Antioch, Ill., and John C., Peace Corps volunteer at Sao Paulo, Brazil.

Dr. Marshall P. Stamm, who had been on the staff at the Veterans Administration Hospital at Wood from January 1961 to January 1964, died May 20, 1965, at the age of 58, leaving a widow, Inez, and one daughter, Mrs. Sandra Kossow.

Doctor Stamm, who was born in Milwaukee, received his M.D. degree at Marquette University School of Medicine and served an internship at Milwaukee Hospital, where later he was an associate staff member. He had also been on the staff of St. Luke's Hospital. For 27 years he was engaged in private practice in West Allis. During World War II Doctor Stamm served in the U.S. Army Medical Corps from Jan. 27, 1944, to June 7, 1946, with overseas service in the European Theater.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

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1965 **Wisconsin**

Aug. 23–26: Marquette University School of Medicine, postgraduate course in treatment of scoliosis and round back, Milwaukee.

Aug. 23–28: Seminar on control procedures in drug production, Wisconsin Center, Madison.

Aug. 26: Wisconsin Academy of General Practice, fifth annual Northwoods symposium, Deer Park Lodge, Manitowish Waters.

Aug. 26–28: University of Wisconsin Medical School course for the surgically oriented physician, Wisconsin Center, Madison.

Sept. 11: Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology and Wisconsin Otolaryngologic Society, Dell View Hotel, Lake Delton.

Sept. 15: Wisconsin State Medical Golf Association, annual fall tournament, Janesville Country Club.

Sept. 20–21: Wisconsin Academy of General Practice, annual scientific assembly, Coach House, Milwaukee.

Sept. 24: Postgraduate course in cancer chemotherapy sponsored by University of Wisconsin extension division, Wisconsin Center, Madison.

Sept. 25: 11th annual fall cancer conference, the "Cancer Scrimmage," sponsored by Wisconsin Division of American Cancer Society and University of Wisconsin Medical School, Wisconsin Center, Madison.

Sept. 30: UW Annual Pediatric Day, sponsored by University of Wisconsin extension division, Wisconsin Center, Madison.

Oct. 8: House of Delegates of State Medical Society of Wisconsin, fall interim meeting, SMS headquarters, Madison.

Oct. 12: Racine–Kenosha Chapter of Wisconsin Academy of General Practice, Eli Lilly symposium, Wingspread auditorium, Racine. (Tentative).

Oct. 13–14: Postgraduate course, "Clinical Application of Current Concepts in Renal Pathophysiology," University of Wisconsin, Madison.

Oct. 15: Wisconsin Society of Internal Medicine, morning postgraduate course on "Chronic Dialysis and Renal Transplantation," followed by annual meeting and scientific program, Wisconsin Center, Madison.

Oct. 16: American College of Physicians, midwest regional meeting, Wisconsin Center, Madison.

Oct. 16: Conference on "Rh Problems and Management," Marquette University, University of Wisconsin, and Wisconsin Obstetrical-Gynecological Society, State Medical Society headquarters, Madison.

Oct. 29–30: Symposium on "Integration of Social Science Concepts in Psychotherapy," co-sponsored by Milwaukee Sanitarium Foundation and Department of Psychiatry, Marquette University School of Medicine, Coach House Motor Inn, Milwaukee.

Nov. 4: "In Depth" teaching program, "Problems Encountered in Aging Process" (Psychiatric), sponsored by University of Wisconsin Medical School, State Medical Society, and Madison Chapter of Wisconsin Academy of General Practice, SMS headquarters, Madison.

Nov. 4–5: Symposium on epilepsy, auspices of Department of Neurology, University of Wisconsin Medical School, Wisconsin Center, Madison.

Nov. 12–14: Wisconsin Society of Pathologists, annual meeting, held jointly with North Central Region of College of American Pathologists, Wisconsin Society of Medical Technologists and Wisconsin Radiological Society, Marquette University, Mamie's Grotto, and Coach House Motor Inn, Milwaukee.

Dec. 1: "In Depth" teaching program, "Problems Encountered in Aging Process" (Medicine), SMS headquarters, Madison.

1965 **Out-of-State**

Aug. 22–27: Flying Physicians Association, 11th annual meeting, Deauville Hotel, Miami Beach, Fla.

Aug. 22–27: American Academy of Physical Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Aug. 30-Sept. 2: American Hospital Association, 67th annual meeting, Civic Auditorium, San Francisco, Calif

Sept. 14–17: American Association of Blood Banks, 18th annual meeting, Americana Hotel, Bal Harbour, Fla.

Sept. 15, 1965-June 15, 1966: Tutorial program in cardiology offered by Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Sept. 15–17: Postgraduate course, "Three Days in Cardiology," sponsored by Council on Clinical Cardiology of American Heart Association, St. Paul Medical Center, and Minnesota Heart Association, Lowry Hotel, St. Paul.

Sept. 15–18: National Commission on Community Health Services and National Health Council, regional conference on community health services, Chicago.

Sept. 16: Seventh International Congress of General Practice, Salzburg, Austria.

Sept. 16–17: Annual West North-Central Interprofessional Seminar on Diseases Common to Animals and Man, University Hospital, Iowa City, Ia.

Sept. 19–25: World Medical Association, 19th world medical assembly, British Medical Association House, London, England.

Sept. 20–Oct. 2: Postgraduate course in laryngology and bronchoesophagology conducted by Department of Otolaryngology of University of Illinois College of Medicine, Illinois Eye and Ear Infirmary, Chicago.

Sept. 21–23: University of Minnesota Department of Pediatrics, continuation course in pediatrics, University of Minnesota campus, Minneapolis.

Sept. 23–25: 11th International Congress of Radiology, Rome, Italy.

Oct. 7–9: American College of Physicians, third fall meeting, Deauville Hotel, Miami Beach, Fla.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 11–13: Academy of Psychosomatic Medicine, annual meeting, Sherman House, Chicago. Joint morning meeting and luncheon Oct. 11 with American Society of Clinical Hypnosis.

Oct. 11–13: University of Colorado School of Medicine, postgraduate course, "The Hospital Medical Staff," Estes Park, Colo.

Oct. 11–14: Committee on Injuries of American Academy of Orthopaedic Surgeons, second postgraduate course on fractures and other injuries, Riviera Motel, Atlanta, Ga.

Oct. 13: Department of Psychiatry and Neurology, Chicago Medical School, start of postgraduate courses in psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists.

Oct. 13–14: American Heart Association Council on Arteriosclerosis, annual meeting, Hotel Deauville, Bal Harbour, Fla.

Oct. 14–16: University of Colorado School of Medicine, postgraduate course, "Medical Education in the Hospital," Estes Park, Colo.

Oct. 15–17: American Heart Association, 1965 scientific sessions, Bal Harbour, Fla. Session on stroke Saturday, Oct. 16.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Oct. 18–22: American College of Chest Physicians, postgraduate course No. 1, "Clinical Application of Cardiopulmonary Physiology," Knickerbocker Hotel, Chicago, Ill.

Oct. 23–28: American Academy of Pediatrics, 34th annual meeting, Palmer House, Chicago.

Oct. 28–30: American College of Gastroenterology, annual course in postgraduate gastroenterology, Americana Hotel, Bal Harbour, Fla.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 28–31: American College of Obstetricians and Gynecologists, District V meeting and nursing conference, Hotel Cleveland, Cleveland, O.

Oct. 30-Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

MEDICAL MEETINGS *continued*

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–4: Southern Medical Association, annual meeting, Houston, Tex.

Nov. 1–5: American College of Physicians, Course No. 18, "Psychiatry for the Internist," University of Colorado Medical Center, Denver.

Nov. 5: International College of Surgeons, divisional meeting, Urbana, Ill.

Nov. 8–12: Course in occupational health for registered nurses in industry, offered by Department of Environmental Medicine of New York University Medical Center in cooperation with American Association of Industrial Nurses, New York University Medical Center.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI conference on obstetric, gynecologic, and neonatal nursing, Pick–Congress Hotel, Chicago, Ill.

Nov. 11–13: Ancker Hospital (Saint Paul–Ramsey Hospital), inaugural scientific program including two days of general medical meetings and one-half day specialty meetings, St. Paul, Minn.

Nov. 15–18: Interstate Postgraduate Medical Association Scientific Assembly, Cleveland, O.

Nov. 15–19: American College of Chest Physicians, postgraduate course No. 2, "Diagnosis and Treatment of Diseases of Heart and Lungs," Barbizon Plaza Hotel, New York City.

Nov. 19–22: National Society for Crippled Children and Adults, annual convention, Palmer House, Chicago, Ill.

Nov. 22–24: 15th Hahnemann Symposium, "Cancer Chemotherapy: Basic and Clinical Applications," sponsored by Department of Medicine, Hahnemann Medical College and Hospital, Sheraton Hotel, Philadelphia 2, Pa.

Nov. 28: Seventh national conference on medical aspects of sports, sponsored by AMA under auspices of AMA Committee on Medical Aspects of Sports, Philadelphia, Pa.

Nov. 28–Dec. 1: American Medical Association annual clinical convention, Philadelphia, Pa.

Dec. 8–10: Hahnemann Symposium, "New Concepts in Gynecological Oncology," Sheraton Hotel, Philadelphia 2, Pa.

1966 **Wisconsin**

Jan. 20: "In Depth" teaching program, "Problems of Elderly Patients" (Surgery and Anesthesia), SMS headquarters, Madison.

Feb. 16: "In Depth" teaching program, "Problems of Elderly Patients" (Dermatology and EENT), SMS headquarters, Madison.

Mar. 24: "In Depth" teaching program, "Problems of Elderly Patients" (Neurology), SMS headquarters, Madison.

Mar. 31–Apr. 2: University of Wisconsin extension division, "Virus Diseases of Childhood," Wisconsin Center, Madison.

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

May 5–7: University of Wisconsin extension division, "Radiology and Pathology of Genitourinary System," Wisconsin Center, Madison.

May 10–12: State Medical Society, annual meeting, La Crosse.

1966 **Out-of-State**

Jan. 16–22: University of Colorado School of Medicine, 12th annual general practice review, Denver, Colo.

Jan. 20–22: World congress on diabetes in tropics, under auspices of Diabetic Association of India, Bombay, India.

Jan. 24–28: American College of Chest Physicians, postgraduate course No. 3, "What's New in Diagnosis and Treatment of Cardiovascular and Pulmonary Diseases," Fontainebleau Hotel, Miami Beach, Fla.

Jan. 24–28: Part I of postgraduate course, "Clinical Pharmacologic Techniques," sponsored by Section of Clinical Pharmacology, Department of Medicine, Hahnemann Medical College and Hospital, and American Therapeutic Society, Marriott Motor Hotel, Philadelphia, Pa.

Feb. 6–13: Canadian-American Medical Dental Ski Association, sixth annual meeting, The Lodge At Vail, Colo.

Feb. 14–18: American College of Chest Physicians, postgraduate course No. 4, "Clinical Application of Cardiopulmonary Physiology," Ambassador Hotel, Los Angeles, Calif.

Feb. 28–Mar. 4: Obstetrics and gynecology seminar cruise to Bahamas, presented by Department of Obstetrics and Gynecology, College of Medicine, University of Florida.

March: Five-day course of instruction in otolaryngologic allergy, sponsored by The University of Tennessee College of Medicine, Memphis.

Apr. 11–13: American College of Chest Physicians, postgraduate course in "Cine-Angiographic Techniques in Cardiovascular Diseases," Cleveland Clinic, Cleveland, O. Tuition, ACCP members, $60; nonmembers, $75.

Apr. 18–22: American College of Physicians, annual meeting, New York City.

Apr. 20–23: 16th Hahnemann symposium, "Arterial Occlusive Disease," postgraduate education course sponsored by Hahnemann Medical College and Hospital, Marriott Motor Hotel, Philadelphia, Pa.

May 16–20: Part II of postgraduate course, "Clinical Pharmacologic Techniques," Marriott Motor Hotel, Philadelphia, Pa.

June 26–July 2: 7th International Congress of Gerontology, Imperial Castle, Vienna, Austria.

Aug. 20–25: 9th International Congress on Diseases of Chest, sponsored by Council on International Affairs of American College of Chest Physicians, H. C. Orsted Institute, University of Copenhagen, Copenhagen, Denmark.

Sept. 11–17: Tenth World Congress of International Society for Rehabilitation of Disabled, Rhein-Main-Hall, Wiesbaden, Germany.

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Oct. 16–20: Interstate Postgraduate Medical Association Scientific Assembly, Washington, D.C.

Program for Epilepsy Symposium

Dr. Francis M. Forster, professor and chairman of the Department of Neurology, University of Wisconsin Medical School, has announced the program for the symposium on epilepsy his department is sponsoring November 4 and 5 at the Wisconsin Center, Madison.

Following a welcome extended by Dr. Peter L. Eichman, dean of the Medical School, Doctor Forster will discuss the aims and scope of the symposium. He will be followed by Dr. James L. O'Leary, professor and head of neurology, Washington University School of Medicine, whose subject will be "Classifications of Epilepsy;" Dr. Richard P. Schmidt, professor and chairman, Department of Medicine, University of Florida, "Causes of Epilepsy;" Dr. Jack D. Grabow, assistant professor, UW Medical School Department of Neurology, "Electroencephalography in Epilepsy;" Charles G. Matthews, Ph.D., assistant professor, Department of Neurology, Neuropsychology Laboratory, UW Medical School, "Neuropsychologic Evaluation of the Epileptic;" Dr. Richard F. Daly, research associate

in genetics, UW Medical School Department of Neurology, "Genetics of Epilepsy;" Dr. H. Houston Merritt, dean of the faculty of medicine, Columbia University, and vice-president in charge of medical affairs, "Medical Treatment of Epilepsy;" Dr. Orlando J. Andy, professor and chairman of neurosurgery, University of Mississippi Medical Center, "Surgical Treatment of Epilepsy;" Doctor Forster, "Conditioning Factors in the Control of Evoked Seizures;" and Dr. Philip T. White, chairman of the Division of Allied Sciences, Barrow Neurological Institute, evening lecture, "The Physician and the Mobilization of Community Resources."

As on the preceding day, the program November 5 will open at 8:30 a.m. Speakers will be George N. Wright, Ph.D., director, Rehabilitation Counseling Research and Training Program, School of Education, University of Wisconsin, and associate professor, Department of Counseling and Behavioral Studies, "Job Placement of the Epileptic;" Lloyd M. Dunn, Ph.D., director, Institute on Mental Retardation and Intellectual Development, George Peabody College for Teachers, "Education for the Epileptic;" Roscoe L. Barrow, J.D., dean, College of Law, University of Cincinnati, "Our Changing Epilepsy Laws;" Dr. Albert Heyman, chairman of the Division of Neurology, Duke University Hospital, "Role of a State Health Service;" Dr. Clifford H. Cole, chief, Neurological and Sensory Disease Service Program, Division of Chronic Diseases, U.S. Public Health Service, "The Neurological and Sensory Disease Service Programs of the U.S. Public Health Service;" Dr. Kathleen E. Lloyd, medical officer, Plans, Policy, and Survey Branch of the Division of State Program Administration, "Role of a Vocational Rehabilitation Administration;" Dr. William Caveness, associate director for collaborative and field research, National Institute of Neurological Diseases and Blindness, "Role of the National Institute of Neurological Diseases and Blindness;" Doctor Forster, summation of the symposium, and Dr. I. Jay Brightman, assistant commissioner of health of the State of New York, conducting afternoon discussion period.

WAGP 1965 Scientific Assembly

Madison, Rochester, and Chicago speakers highlight the 1965 annual scientific assembly of the Wisconsin Academy of General Practice September 20–21 at the Coach House, Milwaukee.

Dr. S. A. Graziano, Milwaukee, chairman of the scientific assembly committee, is in charge of the program, which is acceptable for 10 hours of AAGP credit. It will begin at 9:15 a.m. September 20 following a welcome by WAGP president, Dr. W. D. Hamlin, Mineral Point.

WSMGA Fall Tournament

The Wisconsin State Medical Golf Association will hold its annual dinner and tournament at Janesville Country Club Wednesday, September 15. Turnout for this year's event is expected to exceed the 125 golfers who took part last year. Tee-off time will be 10 a.m.

Trophy events will highlight the tournament play. In the senior event, there will be a trophy for the first low gross, won last year by Dr. F. L. Hummer, Madison, with a low gross of 77. To the golfer with the lowest gross score will go the President's Trophy, captured in 1964 by Dr. F. J. Davis, Madison, who turned in a 76.

Other trophy events will be for the lowest net score for established handicap and the lowest net score for the Callaway system. A prize will also be awarded to the oldest golfer entered. In the tournament last fall, Dr. I. B. Reifenrath, Milwaukee, won this award.

For reservations, physicians are asked to contact Mr. A. H. Luthmers, Executive Secretary, WSMGA, 756 N. Milwaukee St., Milwaukee.

Postgraduate Course in Surgery at UW

Dr. Robert C. Hickey and staff will be host faculty for the postgraduate course in surgery scheduled for August 26–28 at The Wisconsin Center, Madison. Doctor Hickey is professor and chairman of the Department of Surgery at the University of Wisconsin Medical School.

Five guest professors will serve on the faculty along with the Wisconsin Medical Center staff. The five, and their fields of special interest, are: Dr. Frank Glenn, Louis V. Atterbury Stimson, professor of surgery, Cornell University Medical College, and surgeon-in-chief, New York Hospital, cardiac, general, and biliary tract surgery; Dr. Harold Laufman, professor of surgery, Northwestern University Medical School, and attending surgeon, Passavant Memorial Hospital and Veterans Administration Research Hospital, Chicago, surgical aspects of blood coagulation and thromboembolic disease; Dr. George T. Shires, professor of surgery and chairman, Department of Surgery, University of Texas Southwestern Medical School, and general surgeon, Parkland Hospital, Dallas, Tex., general surgery, endocrinology, and surgical physiology; Dr. Clifford D. Benson, clinical associate professor of surgery, Wayne State University Medical School, Detroit, Mich., surgeon-in-chief, Children's Hospital of Michigan, and surgeon, Harper Hospital, pediatric surgery; and Dr. Johann L. Ehrenhaft, professor of surgery and chairman, Division of Cardiovascular and Thoracic Surgery, University of Iowa College of Medicine, Iowa City, Ia., cardiac, pulmonary, and esophageal surgery.

University of Wisconsin faculty serving with Doctor Hickey are Drs. F. J. Ansfield, Maxine Bennett, J. R. Benfield, J. H. Brandenburg, A. R. Curreri, J. W. Gale, James Huffer, Walter Jaeschke, Manucher Javid, R. O. Johnson, William A. Kisken, K. E. Lemmer, B. J. Longley, J. T. Mendenhall, H. I. Okagaki, J. R. Pellett, Flavio Puletti, R. J. Samp, George Steinmetz, Jr., David Uehling, J. B. Wear, Jr., J. D. Whiffen, Herman Wirka, W. H. Wolberg, C. E. Yale, and W. P. Young.

UW Renal Pathophysiology Course

The program has been released for the University of Wisconsin postgraduate course, "The Clinical Applications of Current Concepts in Renal Pathophysiology," which will be held October 13 and 14 at The Wisconsin Center in Madison.

Following registration at 8:15 a.m. October 13, Dr. Peter L. Eichman, dean of the UW Medical School, will deliver the welcoming address. Dr. Neal S. Bricker, St. Louis, Mo., will be the first lecturer, on the subject, "Pathophysiology of Chronic Renal Failure." He will be followed by Dr. Victor E. Pollak, Chicago, "Renal Manifestations of Systemic Disease;" Dr. Richard E. Rieselbach of the UW Medical School Department of Medicine, "Renal Dysfunction Caused by Hyperuricemic States;" Doctors Bricker, Pollak, Herbert Lubowitz, Lewis W. Bluemle, Jr., and John H. Dirks, panel discussion and question period; Dr. David P. Earle, Chicago, "Natural History of Glomerulonephritis;" Dr. George Gee Jackson, Chicago, "Acute and Chronic Pyelonephritis;" Dr. Edward J. Lennon, Milwaukee, "Disorders of Fluid-Electrolyte and Acid-Base Metabolism;" Dr. J. M. B. Bloodworth, Jr., UW Medical School professor of pathology, "Diabetic Nephropathy," and Doctors Earle, Jackson, Lennon, Bloodworth, and George E. Schreiner, panel discussion and question period.

The October 14 program will be opened by Doctor Schreiner, Washington, D. C., with a paper on "Pathophysiology of Acute Renal Failure." It will continue with lectures by Doctor Jackson on "Therapy of Chronic Pyelonephritis;" Doctor Pollak, "Therapy of Glomerulopathies;" and Doctor Lubowitz, St. Louis, Mo., "Micropuncture of the Normal and Diseased Kidney;" a panel discussion and question period with Doctors Schreiner, Jackson, Pollak, Lubowitz, and Lennon participating; papers by Doctor Dirks, Bethesda, Md., "Regulation of Renal Sodium Excretion;" Doctor Bluemle, Philadelphia, "Design and Evaluation of Hemodialytic Systems;" Dr. Arvin B. Weinstein, UW Medical School Department of Medicine, "Dextran Gel Filtration of Uremic Blood;" Dr. William T. Newton, St. Louis, Mo., "Renal Transplantation and Organ Preservation;" panel discussion and question period with Doctors Dirks, Bluemle, Weinstein, and Newton taking part, and the summation by Doctor Bricker.

Doctors Rieselbach and Weinstein will share the duties of chairmen for the course.

Registration fee is $40.00. Checks and registration forms should be sent to: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison, Wis. 53706.

Requests for housing must be received prior to September 14. Housing forms should be mailed to Mrs. J. Thomas, Box 490, Edgewater Hotel, 666 Wisconisn Ave., Madison.

Registrants are invited to attend two subsequent meetings at The Wisconsin Center: a morning symposium on "Chronic Dialysis and Renal Transplantation" October 15 presented by the Wisconsin Society of Internal Medicine, and the Midwest Regional Meeting of the American College of Physicians October 16.

Ophthalmology, Otolaryngology Meeting

A joint meeting of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology and the Wisconsin Otolaryngologic Society will convene at 9 Saturday morning, September 11, at the Dell View Hotel, Lake Delton. All interested physicians are welcome.

Guest speakers for the two-day program will be Dr. G. O'Neal Proud, professor and head of the Department of Otorhinolaryngology, University of Kansas Medical Center, and Dr. Robert C. Watzke, professor, Department of Ophthalmology, University of Iowa. Doctor Proud will present papers on the topics, "A Surgical Approach to Refractory Otitis Externa" and "Concepts of Secretory Otitis Media." Doctor Watzke's papers will be on the subjects, "External Infections of the Eye" and "Stereoscopic Fundus Photography and Angiography." Mr. Lee Allen will aid in presentation of the latter subject.

WSIM Annual Meeting

Dr. George E. Gutmann, Janesville, president of the Wisconsin Society of Internal Medicine, will deliver the welcome when the Society holds its 1965 annual meeting and scientific program Friday, October 15, at the Wisconsin Center in Madison.

Speakers at the morning session will be Dr. Robert E. Burns, Veterans Administration Hospital, Madison, "Peritoneal Dialysis;" Dr. Antonio Versaci, Morton Grove, Ill., "Hemodialysis;" Dr. Jerry P. Pendras, medical director of the Seattle Artificial Kidney Center, Swedish Hospital, Seattle, Wash., "Chronic Renal Dialysis with Artificial Kidney;" Dr. James E. Clark, assistant professor of clinical medicine, Jefferson Medical College of Philadelphia, Philadelphia, Pa., "Jejunal Loop Irrigation for Home Dialysis in Chronic Uremia," and Dr. Thomas E. Starzl, professor of surgery, University of Colorado Medical School, Denver, "Kidney Homo Transplants." All morning speakers will participate in a panel discussion moderated by Dr. Donald A. Roth, assistant professor of medicine at Marquette University School of Medicine, Milwaukee, on the subject, "Kidney Failure Patients Do Not Have To Die."

Following the annual meeting luncheon, the afternoon program will open with the William S. Middleton lecture, "Fluid and Electrolyte," by Dr. Gerald A. Kerrigan, dean of Marquette University School of Medicine. Dr. A. A. Quisling, Madison, WSIM president-elect, will serve as moderator for a panel discussion on "The Internist and Rapidly Changing Medical Socio-Economics." Panelists will be Dr. Robert E. Westlake, New York City, president of the American Society of Internal Medicine, and three trustees of the ASIM: Dr. Robert S. Long, Omaha,

Neb., Dr. Peter J. Talso, Hines, Ill., and Dr. Robert L. Gilbert, La Crosse.

The annual meeting banquet is scheduled for 6:30 p.m. in the "Hall of Wisconsin" of the Park Motor Inn.

UW Cancer Course, Conference

All physicians are invited to attend a practical course in cancer chemotherapy directed by Drs. A. R. Curreri and F. J. Ansfield September 24 at University Hospitals, Madison. At a reception and dinner that evening, Dr. Paul Kotin of the National Cancer Institute will speak. The program dovetails with the annual fall cancer conference the following day, at which the featured speaker will be Dr. James T. Grace, Jr., assistant director of Roswell Park Memorial Cancer Institute.

National Heart Meet

More than 150 heart specialists from throughout the country are expected to attend "Three Days in Cardiology" at the Lowry Hotel, St. Paul, September 15–17, under the sponsorship of the Council on Clinical Cardiology of the American Heart Association, the St. Paul Medical Center, and the Minnesota Heart Association.

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Special Issue: Pediatrics

Etiological Diagnosis of Antimicrobial Therapy of Respiratory Infections in a Pediatric Practice

By JAMES J. NORA, M.D., FRANK K. JOHNSON, M.D., L. WILLIAM KLEPPE, M.D., and JAMES E. OPDYKE, B.S., Madison, Wisconsin

■ CLINICAL INVESTIGATORS such as Dingle et al[1] report that only 2.5 per cent of respiratory infections are of bacterial origin. Other studies by Evans and Brobst,[2] Hilleman et al,[3] and Wenner et al[4] support the observation that bacterial infections account for only a small percentage of respiratory disease. These studies are valid for the populations which they encompass, but the question is raised: can such figures from academic centers be applied to a population actively seeking medical care in a pediatric practice?

The etiology of a respiratory infection is not easy to define. The practicing physician does not have the facilities to do the type of evaluation performed by Sterner and Tunevall[5] who obtained viral and bacterial cultures plus serological studies on their patients. Also, the average patient cannot afford such a study. However, even when such sophisticated evaluations are performed the results are disappointing. Sterner and Tunevall were only able to diagnose "fresh infection," viral or bacterial, in one-third of the cases, and two-thirds of these "fresh infections" were mixed.

If the practicing physician is going to supplement his clinical judgment by laboratory means, he is most likely to use bacterial nose and throat cultures. Yet the serious limitations of nose and throat cultures must be acknowledged. One limitation emphasized by Box et al[6] is that, if careful techniques are employed, bacterial pathogens may be discovered in the upper respiratory tracts of almost all children, and that a distinction between those having respiratory tract infections and those free from infection cannot

Doctor Nora is an Assistant Professor, Department of Pediatrics, University of Wisconsin Medical School, Madison; and was associated with the Beloit Clinic, Department of Pediatrics, Beloit. Doctor Johnson is also associated with the Beloit Clinic, Department of Pediatrics. Doctor Kleppe and Mr. Opdyke are associated with the Beloit Municipal Hospital, Beloit.

This study was supported by grants from Lederle Laboratories, Roche Laboratories, and Wyeth Laboratories.

be made on the basis of qualitative or quantitative growth of these organisms on culture.

From an academic viewpoint it appears almost presumptuous to attempt to make an etiological diagnosis of respiratory infections. However, the practicing pediatrician must make such diagnoses 10 to 30 times a day to permit optimal utilization of antimicrobial therapy.

Thus, the second question to which this study addresses itself is raised. How does the practicing physician distinguish a bacterial from a nonbacterial infection and how accurate is he in defining the etiology of respiratory infections?

Having gained information on how frequent bacterial infections are in pediatric practice and how accurately the diagnoses are made, it is appropriate to ask a third question: how effective is antimicrobial therapy under the routine conditions of its use in a pediatric practice?

Materials and Methods. A total of 389 patients from a private pediatric practice were studied in the late winter and early spring of 1962. The population had an age range of 4 weeks to 15 years. Of the patients, 278 had clinical respiratory infections, and no antimicrobial therapy for one month prior to being studied. They were initially seen in the office, on home calls, or in the hospital. Another group of 107 patients, to serve as controls, was comprised of infants and children seen at well-baby and well-child examinations and found to be clinically free from infection. Incomplete data were obtained on 4 patients.

To ascertain the frequency of bacterial respiratory infections in our practice, the 278 patients with clinical respiratory infections and the control group of 107 patients clinically free from respiratory infection were investigated on initial contact by taking nose and throat cultures, and complete blood counts. Pharyngeal and nasopharyngeal cotton swabs were obtained, placed in Stuart's transport medium[7] and plated within one to a maximum of 15 hours from the time the specimens were taken.

In addition to the standard blood agar and chocolate agar culture plates, three other plates were made initially from the swabs: an eosin methylene blue, a glycine tellurite, and a small blood agar with a bacitracin disk and an ethylhydrocupreine (Optochin) disk. Subcultures were obtained in the usual manner. For streptococci, fluorescent antibody and precipitin grouping were performed. Staphylococci were checked for coagulase activity.

To test the accuracy of our clinical impressions, the 278 patients with respiratory infections were each judged on clinical grounds alone as having one of the three: a bacterial infection, a nonbacterial infection, or an infection of equivocal etiology but deserving antimicrobial therapy. A specific diagnosis such as otitis or "strep throat" was also assigned to each patient. The clinical impression as to the possible bacterial etiology of the infection was then confirmed or denied by the laboratory studies taken in the total context of the illness.

A double-blind study of oral antimicrobial therapy was performed on 216 patients. These were patients whose condition in the clinical judgment of the authors justified antimicrobial therapy, but who were not so seriously ill as to be unable to tolerate the risk of a double-blind study.

The three antimicrobial agents used were the ones the authors most commonly employed in their practice: penicillin V,* tetracycline,† and sulfadimethoxine.‡ The drugs were prescribed in the situations and for the indications for which they had routinely been prescribed in the past. It was the design of the study to maintain the conditions of pediatric practice to accurately test the effectiveness of antimicrobial therapy as routinely applied. Apparent "strep throats" and the more severe infections received penicillin. The less severe infections of more questionable bacterial etiology (or possible "H flu") received tetracycline, and the mildest and least-likely-to-be bacterial infections received sulfadimethoxine, because this was the way the authors had been using these medications, not because this is necessarily the ideal way to employ the drugs. Penicillin V was prescribed in a dose of 125 mg every six hours; tetracycline, 10 to 20 mg per pound of body weight daily, given four times a day; and sulfadimethoxine given once a day, 25 mg per pound the first day and 12.5

* Trade Name: Pen Vee K Liquid and placebo, kindly supplied by Wyeth Laboratories.

† Trade Name: Achromycin V syrup and placebo, kindly supplied by Lederle Laboratories.

‡ Trade Name: Madribon suspension and placebo, kindly supplied by Roche Laboratories.

mg per pound on subsequent days. Each patient was started on his antimicrobial agent (or its respective placebo) on initial contact.

Four days after the initial visit each patient was reexamined and another clinical judgment was made (with the benefit of the results of the culture and blood studies). At this time the patient was judged to be recovered, improved, unchanged, or worse on the basis of the clinical findings, and without the knowledge of whether the prescribed antimicrobial agent or its placebo had been used. Depending on the clinical indications, changes in therapy were instituted and repeat cultures obtained. In a few instances the condition of the patient worsened sufficiently, before the four-day examination, to necessitate immediate changes in therapy. On the occasions when a patient was found to have beta-hemolytic Streptococcus group A on his culture, a full antistreptococcal regimen was immediately instituted (1,200,000 units of benzathine penicillin G [Bicillin] intramuscularly or ten days of penicillin V orally). In these special cases the clinical condition was recorded as of the day the patient was reexamined.

Results. Table 1 shows that 25 per cent of the patients with respiratory infections were eventually accepted as having bacterial infections. The diagnostic categories into which these patients were placed is also displayed. Although no serious effort was made to duplicate the work of Breese[8] in making the specific diagnosis of "strep throat," the authors felt confident in assigning the diagnosis of "strep throat" to 15 patients. Only 8 of these patients had beta-hemolytic Streptococcus group A. Most of the others had Staphylococcus aureus which was not accepted as the etiological agent, and therefore the infections were arbitrarily assumed not to be bacterial.

The decision as to what constituted a bacterial infection was not made with facility. Major reliance was placed on the cultures. If an organism which is generally accepted as pathogenic to the respiratory tract was isolated in pure culture or as a predominating organism in the presence of a clinical respiratory infection, the assumption was made that this was a bacterial infection. The three major organisms accepted were beta-hemolytic Streptococcus group A, Hemophilus influenzae and Diplococcus pneumoniae. Such an approach is consistent with

TABLE 1—*Etiology of Respiratory Infections According to Clinical Diagnosis*

Diagnostic Category (based only on history and physical findings)	Etiology		
	Bacterial	Non-bacterial	Total
1. tonsillitis-pharyngitis	18	59	77
2. follicular tonsillitis	5	7	12
3. "strep throat"	8	7	15
4. bronchitis	1	47	48
5. bronchiolitis	0	2	2
6. croup	0	15	15
7. "clinical pneumonitis"	2	5	7
8. influenza	0	7	7
9. sinusitis	6	11	17
10. otitis	27	20	47
11. coryza	3	26	29
12. other	0	2	2
Total Cases	70 (25%)	208 (75%)	278

recommendations in the literature and current textbooks.[9, 10] Patients with beta-hemolytic Streptococcus group A as a secondary organism, but with a high colony count, were accepted as having bacterial infections, although the organism was not predominating or in pure culture. A fairly large number of infections, most of them otitis media with intact tympanic membrane, which were eventually accepted as bacterial in etiology failed to yield an organism that could be considered unequivocally a respiratory tract pathogen. Assumptions were made that the infections were indeed bacterial but the organism had not been isolated.[11, 12]

Similar assumptions were made when Staphylococcus aureus was isolated from a draining ear or from a throat in the presence of a "clinical" bacterial infection. Unanimity of opinion is lacking on the role of Staphylococcus aureus as an upper respiratory tract pathogen.[9-11, 13] The authors took the position that the Staphylococcus organism was not necessarily the etiological agent, but arbitrarily assigned a bacterial label to many of these infections because of the total picture presented.

The organisms isolated from the groups with and without respiratory infections are listed in Table 2. Ten per cent of the children with respiratory infections had positive cultures for group A beta-hemolytic Streptococcus and even more had nongroup A beta-hemolytic Streptococcus on culture. A disproportionate number of patients with respiratory infections are noted to have Staphylococcus aureus and gram-negative enteric organisms on culture when compared with the group free from respiratory infection. Such a finding supports those who accept staphylococci as respiratory tract

TABLE 2—*Organisms Isolated from Groups with and without Respiratory Infections*

Predominating Organisms	Group With Respiratory Infections	Group Without Respiratory Infections
beta-hemolytic Streptococcus group A	28 (10%)	3 (3%)
beta-hemolytic Streptococcus not group A	30 (11%)	9 (8%)
Diplococcus pneumoniae	10 (4%)	0 (0%)
Hemophilus influenzae	5 (2%)	1 (1%)
Staphylococcus aureus	40 (14%)	4 (4%)
Klebsiella pneumoniae	1	0
alpha-hemolytic Streptococcus	102	73
gamma-hemolytic Streptococcus	5	2
Neisseria species	19	13
Staphylococcus epidermidis	6	0
Diphtheroid bacilli	2	0
Aerobacter	14	0
Escherichia coli	10	2
Proteus	3	0
Pseudomonas aeruginosa	2	0
Complete studies	278	107
Incomplete studies	3	1
Total studies	281	108

TABLE 3—*Accuracy of Clinical Diagnosis*

Initial Diagnosis by History and Clinical Findings		Final Diagnosis based on Laboratory and Clinical Findings		Results	
		Bacterial	Nonbacterial	Correct	Incorrect
Bacterial Infection	114	56	58	56	58
Nonbacterial infection	128	6	122	122	6
Equivocal	36	8	28		
Totals	278	70	208	178 (74%)	64 (26%)
Chi-square =		53.6	P < 0.001		

pathogens, but raises the additional question of a possible similar role for some gram-negative organisms.

The ability of the pediatricians to distinguish bacterial from nonbacterial respiratory infections by history and physical findings alone is demonstrated in Table 3. The correct judgment was made 74 per cent of the time as to whether a respiratory infection under consideration was bacterial or nonbacterial.

The error was almost invariably in overdiagnosis of bacterial infections. Ultimately only 25 per cent of the infections were accepted as bacterial in origin, but almost 50 per cent were judged to be bacterial on initial clinical impression. However, only six times was there failure to diagnose a bacterial infection when confronted by it.

In Table 4 are recorded the results of the double-blind study, using the three antimicrobial agents. It should be emphasized that this investigation was not designed to evaluate the drugs employed in the study,

TABLE 4—*Results of Antimicrobial Therapy*

Medication	Improved	Unimproved	Tota %
ALL RESPIRATORY INFECTIONS TREATED WITH SULFADIMETHOXINE			
Sulfadimethoxine	25 (70%)	11 (30%)	100
Placebo	19 (63%)	11 (37%)	100
Total patients	44	22	
Chi-square =	0.492	0.50 > P > 0.30	
ALL RESPIRATORY INFECTIONS TREATED WITH TETRACYCLINE			
Tetracycline	25 (72%)	10 (28%)	100
Placebo	22 (57%)	17 (43%)	100
Total patients	47	27	
Chi-square =	2.91	0.10 > P > 0.05	
ALL RESPIRATORY INFECTIONS TREATED WITH PENICILLIN V			
Penicillin V	29 (73%)	11 (27%)	100
Placebo	21 (56%)	15 (44%)	100
Total patients	50	26	
Chi-square =	3.75	0.10 > P > 0.05	

TABLE 5—*Results of Antimicrobial Therapy*

Medication	Improved	Unimproved	Total %
NONBACTERIAL INFECTIONS			
Antimicrobial therapy	54 (65%)	29 (35%)	100
Placebo	49 (58%)	35 (42%)	100
Total patients	103	64	
Chi-square =	0.85	0.50 > P > 0.30	
BACTERIAL INFECTIONS			
Antimicrobial therapy	25 (86%)	4 (14%)	100
Placebo	13 (62%)	8 (38%)	100
Total patients	38	12	
Chi-square =	7.18	0.05 > P > 0.01	

but rather the effectiveness of these drugs as utilized by clinicians in pediatric practice. It is obvious that the three drugs cannot be compared because each was given for different indications. Sulfadimethoxine failed to give significantly better results than those obtained with the placebo. The results with tetracycline and penicillin V suggest that the physicians were using these medications more effectively. However, neither penicillin nor tetracycline, when compared with their respective placebos, achieved results that were acceptable at a level of statistical significance of $P < 0.05$.

The source of the failure of the antimicrobial therapy may be inferred from Table 5. There was essentially no difference between the treated and untreated nonbacterial infections, as might have been expected. The statistical significance of the results of

antimicrobial therapy came, also as might have been expected, from treating bacterial infections with antimicrobial agents.

It is obvious from Tables 4 and 5 that if the physician is not highly discriminating in his use of antimicrobials, he treats too many nonbacterial infections and thus achieves results with antibacterial drugs which are not significantly better on statistical analysis than results with placebos.

Discussion. In answer to the questions proposed at the beginning of the study, the authors found that approximately 25 per cent of the patients in their pediatric practice who have respiratory infections could be accepted as having infections of bacterial etiology. This figure is in contrast with the finding of Dingle et al[1] that 2.5 per cent of respiratory infections are of bacterial origin. The population in this study is more representative of actual practice experience in pediatrics because the pediatrician, in trying to evaluate the appropriateness of his antimicrobial therapy, is interested in the percentage of children seeking medical attention who have bacterial respiratory infections. The percentage of patients in the general population with mild respiratory infections not requiring medical attention is less applicable if applied to the pediatric practice situation.

While the clinical judgment of the authors in distinguishing bacterial from nonbacterial respiratory infections without the benefit of cultures proved to be satisfactory statistically, it did not provide a degree of accuracy to permit optimal utilization of antimicrobial agents. Recognizing the limitations of nose and throat cultures, the authors, nevertheless, submit that the use of culture material in almost all patients with respiratory infections can be a significant supplement to clinical judgment.

Utilizing the office laboratory, the physician can obtain a nose and throat culture on every patient from whom he withholds antimicrobial therapy. With the probable exception of patients with otitis media, all patients started on antimicrobial therapy as an emergency measure also deserve cultures. For home calls, Stuart's transport medium could be employed. Cultures may then be plated promptly on divided blood agar—chocolate agar disposable Petri dishes with a bacitracin disk and ethylhydrocupreine disk. The cost at present is less than a dollar per patient and even pediatricians, long-unaccustomed to the bacteriology laboratory, can accurately (and enjoyably) identify beta-hemolytic Streptococcus group A, Pneumococcus, hemolytic Staphylococcus and H. influenzae. Details of such an office procedure may be found in the article by Markowitz.[11]

When employed judiciously for specific bacterial infections the antibiotics and chemotherapeutic agents contribute immeasurably to the armamentarium of the practicing physician and to the health of his patients. The fact that these drugs are so abused is perhaps really a measure of their success. The physician and patient have become so accustomed to the miracle that the antimicrobials have achieved, when appropriately used, that an unconscious and unjustified expectation of a miracle is present even when the medication is used inappropriately.

An example of this is the feeling many practicing physicians share that antimicrobial agents are useful in respiratory infections even in the absence of bacterial involvement "because they prevent bacterial complications." Townsend and Radebaugh[14] found this assumption to be unsupported in a double-blind study. Our findings on Table 5 are in complete agreement with this. Petersdorf has reviewed the problem and finds antimicrobial prophylaxis, except for specific pathogens, "based more on wishful thinking than on factual information."[15]

In general, the antimicrobial therapy of the bacterial respiratory infections was extremely effective. Only four times in the study did the initially selected antibacterial agent fail to produce satisfactory improvement, and one of these failures was in a very rare case of childhood Friedlander's pneumonia. The majority of the so-called therapeutic failures in this study came from illogically trying to cure a nonbacterial infection with an antibacterial drug.

The authors have concluded that withholding antibiotics in nonemergent situations until culture results are obtained could greatly increase the accuracy of diagnosis and the effectiveness of antimicrobial therapy by eliminating those cases doomed to failure because they are not appropriate for antibacterial treatment. In an emergency the clinical judgment and drug selected are likely to be quite valid. The judgment may be modified by the results of the culture. There appears to be no logical clinical reason to

give antimicrobials on initial patient contact in nonemergent situations when culture results which could determine specific therapy can be obtained in 24 hours.[11]

As might have been anticipated, the attempt to answer the proposed questions was greeted by further questions. What constitutes a fresh bacterial infection is far from answered. Also obscure is the significance of gram-negative organisms and Staphylococcus aureus seen much more frequently in the group with respiratory infections than in the group free from infection.

It has thus been demonstrated that bacterial respiratory infections are frequent in a population seeking medical attention; that the diagnosis of bacterial infections without the aid of cultures is reasonably accurate but unfortunately not accurate enough to permit optimal utilization of antimicrobial agents; and that when antimicrobial agents are not used optimally, they have little more effect than placebos.

Summary. Three hundred and eighty-nine patients from a private pediatric practice were studied to determine the etiology of infections, the ability to distinguish bacterial from nonbacterial respiratory infections on the basis of the history and physical findings alone, and the effectiveness of antimicrobial therapy under the conditions of its use in a pediatric practice.

By the criteria described in the study, 25 per cent of the children with respiratory infections were judged to have infections of bacterial etiology.

The authors were able to correctly judge the bacterial or nonbacterial nature of the infections in 74 per cent of the cases on the basis of the history and physical findings alone. The source of error was almost entirely in diagnosing as bacterial a nonbacterial infection. Only six bacterial infections were diagnosed incorrectly as being of nonbacterial origin.

In a double-blind study, when compared with its placebo, none of the three drugs used (penicillin V, tetracycline, and sulfadimethoxine) achieved a level of $P < 0.05$ in producing clinical improvement of the respiratory infections under treatment. The failure to demonstrate a significant difference was directly related to the large number of nonbacterial infections which were treated with antimicrobials because the physicians were incorrect in selecting the cases for antimicrobial therapy.

More liberal use of cultures as an office procedure is suggested to increase the accuracy of etiological diagnosis and to permit more effective use of antimicrobial agents.

The study demonstrates that bacterial respiratory infections are much more common in routine practice than is described in epidemiological surveys. It also shows that, although the diagnosis of bacterial infections without the aid of cultures is reasonably accurate, it is not accurate enough to allow optimal use of antibacterial drugs. Further, when antimicrobials are not used optimally they do not achieve significantly better results than placebos.

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* * *

SOME FOUR MILLION CHILDREN catch measles every year in the United States with about 500 deaths resulting. Serious complications may occur once in every 400 cases. Vaccines now can prevent this illness, even for babies as young as one month.—*Pharmaceutical Manufacturers Association.*

SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1965—December 31, 1965

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION
MADISON, WISCONSIN 53703

Location	*Date*	*Location*	*Date*
Ashland	August 4 and 5	Eau Claire	September 29 and 30
Manitowoc	August 11 and 12	Kenosha	October 12 and 13
Stevens Point	August 18	La Crosse	October 19 and 20
Marinette	September 8	Chippewa Falls	October 27 and 28
Superior	September 15	Sheboygan	November 2 and 3
Racine	September 22 and 23	Rhinelander	November 10 and 11

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 110 North Henry Street, Madison, Wisconsin 53703.

Need for Early Diagnosis of PKU

By HARRY A. WAISMAN, Ph. D., M. D., Madison, Wisconsin

Introduction

NEARLY EVERY PHYSICIAN has under his care some individual with mental retardation. It is now becoming clear that an early differentiation of the type of retardation, and an accurate assessment of the patient will help provide optimum care and proper supervision. Since infants and children with mental retardation and poor development usually come to the attention of physicians, all of us should be as well informed as possible. Certain causes of retardation in children, especially those with a metabolic abnormality allow for relatively better prognosis if properly treated. One such disease is phenylketonuria (PKU).

The Disease

PKU is a well recognized hereditary disease characterized by mental retardation and caused by a defect in the metabolism of the amino acid phenylalanine. While the exact cause of the brain damage is not completely understood, early diagnosis is a "must" because immediate dietary treatment with a low phenylalanine diet will lessen or prevent the severe mental retardation. The earlier the treatment is begun, the better the ultimate development of the child.

The incidence of PKU (1 in 10,000 live births) is now greater than previously supposed. For any particular family that carries the abnormal trait, there is a 1 in 4 chance with each pregnancy that the child will have phenylketonuria.

The physician is thus challenged to make an early diagnosis of this inborn error of metabolism as one example of many similar diseases (i.e., galactosemia, histidinemia, maple syrup urine disease, homocystinuria, etc.) for which diagnostic procedures will and are becoming available. PKU can now be detected by both urine and blood tests and the physician responsible for the care of infants and children can help accomplish these practical diagnostic tests.

The Tests

An affected PKU child cannot convert phenylalanine to tyrosine and in most cases will show a blood phenylalanine level sufficiently high by the 7th day to allow phenylketones to appear in the urine. When these phenylketones are excreted, the stick test (Phenistix) and the 5% ferric chloride test on the wet diaper will be positive with an accuracy of more than 95%. Mass screening tests on the blood using the bacterial inhibition technique of Guthrie are not yet available in all hospitals in Wisconsin.

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Although this blood test is the best developed thus far for large populations, the physician must rely upon urine tests until comprehensive mass screening tests on blood are available. Therefore, physicians should perform a PKU test on the moistened diaper on every baby between the 10th and 14th day of age. These tests may give misleading false negative results if the test is performed too early.

The present day pattern of discharge of infants from the newborn nursery by the third or fourth day tends to discourage testing the baby's urine at the prescribed interval. It is suggested that physicians should have every baby return to the office between the 10th and 14th day for a test of phenylketones in the urine. Further it is advisable to have the diaper test performed again at four weeks of age for further confirmation.

The Challenge

The physician's responsibility to do the tests for phenylketonuria in his own office will necessitate a change from the old established pattern of seeing the infant in the office for the first time at six weeks of age. This practice has only tradition to recommend it, and an earlier neonatal office visit is indicated not only for the early detection of congenital anomalies, manifestations of inborn metabolic diseases, but also to begin a comprehensive immunization program.

Any positive urine test must be confirmed by a quantitative blood phenylalanine test. Should the blood phenylalanine be elevated and phenylketones appear in the urine, immediate dietary therapy can be instituted with the expectation of reasonably good intellectual development.

Recommended Procedure for Infant Testing in Wisconsin

In Hospital—Guthrie blood test only after 4th or 5th day.

In Office—On 10th to 14th days after birth.
- (a) general examination
- (b) urine test for PKU with $FeCl_3$ or Phenistix
- (c) urine test for reducing substances; i.e., glucuse, galactose, etc.

at 4th week.
- (a) general examination
- (b) urine test with $FeCl_3$ or Phenistix

In an early issue of the WISCONSIN MEDICAL JOURNAL a more comprehensive article describing various aspects of the disease and the results of treatment will be published. The value of other tests soon after birth will also be discussed.

Newer Techniques in the Diagnosis of Children's Urinary Tract Infections

By DAVID UEHLING, M. D., Madison, Wisconsin

■ THE FREQUENCY of pediatric urinary tract infections is distressing to all who are concerned with the care of children. With newer diagnostic techniques, an increasing number of correctable causes is being found for these infections. Early treatment is the key to preventing the cycle of recurring infections and their sequelae of renal damage.

Incidence and Long-Term Effects. Kunin has recorded a 1 per cent incidence of asymptomatic but significant bacteriuria from a series screening female school children.[1] After becoming symptomatic, female children with urinary tract infections have an 80 per cent chance of developing one or more recurrences. Of the children hospitalized for urinary tract infection, over half eventually develop the serious sequelae of chronic pyelonephritis or renal insufficiency.[2] To combat these awesome statistics, more vigorous diagnostic evaluations are being employed to look for specific remedial causes in each child with an initial urinary tract infection. Specific abnormalities causing the infections are being found in ever-increasing yield.

Depending on the vigor and sophistication of the methods used in diagnosis, up to 70 per cent of the children evaluated will be found to have an obstructing lesion in the urinary tract. In Kunin's series of female school children with asymptomatic bacteriuria, there were abnormalities demonstrated in 22 per cent of the patients on intravenous pyelography and in 44 per cent on voiding cystourethrogram. Almost all male children with a urinary infection will have a definite diagnosable cause requiring correction.

Diagnostic Tests. There are five important steps in the evaluation of a child with a urinary tract infection. All need not be done on each child, and the clinician must decide in each individual case which steps are necessary.

The intravenous pyelogram is the most frequently used initial step. It remains indispensable. All other tests are related to the findings on the intravenous pyelogram. To evaluate radiographically the bladder and urethra, the voiding cystourethrogram is added; and, in children, the yield of abnormalities will be twice as high as on the intravenous pyelogram. This test requires catheterizing the child, but the opportunity can be taken to measure residual urine and obtain an additional, more reliable urine culture.

A small Foley catheter or polyethylene feeding tube may be used for the catheterization. The bladder is filled with radiographic contrast media by gravity from a sterile container held 30 cm over the pubic symphysis. When the child expresses discomfort or the desire to void, the catheter is removed. X-ray films are taken when the child is seen to be voiding with a good stream so that the urethra will be well filled. The lateral projection is best suited to show significant obstructing lesions in the urethra or at the bladder neck.[3]

Figure 1 shows a bladder neck contracture as seen in the lateral projection. A narrow bladder neck relative to the proximal urethra as seen in the anteroposterior view is a common finding, and is not a specific sign of bladder neck contracture. Figure 2 shows a posterior urethral valve with the associated dilatation of the proximal urethra and a secondary contracture at the bladder neck area. The latter will usually disappear after the more distal obstructing valve is treated with transurethral resection. During the voiding cystourethrogram, a film of the abdomen is

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Fig. 1—Bladder neck contracture.

Fig. 2—Posterior urethral valve.

Fig. 3—Normal female voiding cystourethrogram.

Fig. 4—Bougie a boule for urethral calibration.

taken to determine the presence of vesicoureteral reflux.

A more sophisticated method than the taking of spot films during voiding is the viewing of the whole act of voiding by fluoroscopy, and by making a movie for reviewing. This cinecystourethrography requires more expensive equipment but is more sensitive in detecting transitory and slight degrees of reflux.

One problem engendered by urethrography in children with urinary tract infections is that the degree of dilatation of the urethra that may be present and still be normal, especially in females, is not known. If the urethra in the female child is dilated down to the external meatus, a meatal stenosis may be found or the meatal calibre may be normal. Figure 3 shows a urethrogram which did not show widening and was misleading since this child was found to have meatal stenosis and improved with dilatation.

The most conclusive step in the diagnostic examination is still direct cystoscopic visualization of the bladder and urethra. Several crucial factors are readily determined. With the child asleep, the calibre of the urethra, and particularly the meatus or external opening, can be measured. This is the most common point of obstruction in little girls with bladder infection. The calibre is best determined with the bougie a boule (Fig 4).

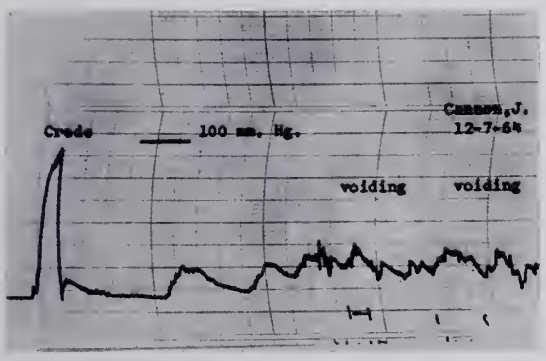

Fig. 5—Normal voiding pressure tracing.

Due to its acorn-shaped tip it passes easily into the bladder, but its back edges catch on constrictions less wide than its diameter. Starting with small sizes, progressively larger sizes are passed until there is a "catch" sensation or blanching of the meatus. Another common point of obstruction is a membranous ring found half a centimeter inside the meatus of the female urethra. This distal urethral membrane has been thought by some to be responsible for 70 per cent of urinary infections in female children.[4] The membrane opens on the passage of the usual urologic instruments and its presence may explain why these children unexplainedly have improved after cystoscopy.

Cystoscopy may reveal trabeculation of the bladder or coarsening of the muscle fibers due to straining against some kind of obstruction. The degree of scarring around the ureteral orifices and the length of the intramural ureter can be estimated. These are a guide to prognosis and the duration and vigor of treatment necessary.

Another measurement utilizing the same anesthetic is the intravesical pressure during voiding. A No. 17 Intracath is inserted into the full bladder by midline puncture just above the pubic symphysis. The catheter is connected to a strain gauge and recorder, or less optimally, to a water manometer. As the children awake from anesthesia, those with a full bladder almost invariably void before movements or coughing begins. The intravesical pressure is thus recorded without any catheter in the urethra. Figure 5 shows a normal tracing. Children with bladder outlet obstruction void with greater than 40 mm of Hg rise in pressure.[5]

With the same recording apparatus, recordings of ureteral peristalsis may be made through a catheter passed into the ureter. Reflux and infection are known to destroy ureteral peristalsis and the process is only partially reversible. If a ureter is dilated and shows poor peristalsis, it is not wise to re-implant it into the bladder in an attempt to prevent reflux. The new course through an oblique muscle tunnel will only make it harder for the ureter to empty and cause more dilatation. Instead, the regimen of double or triple voiding can be used to get better emptying of renal pelvis, ureter and bladder, as employed effectively by Stephens and others.[6]

Five diagnostic steps should be considered in most children with urinary tract infection if the sequelae of recurring infection, chronic pyelonephritis, and renal insufficiency are to be prevented. The current yield of correctable abnormalities found justifies the expense and effort expended on behalf of these children.

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RARE HEART AILMENT LINKED TO MUMPS IN EARLY PREGNANCY

A case of mumps during early pregnancy may cause a rare form of heart disease in the newborn, say scientists at the University of Minnesota School of Medicine. According to Dr. Joseph St. Geme, Assistant Professor of Pediatrics and Microbiology, and Dr. George Noren, Instructor in Pediatrics, a "highly suspicious" relationship seems to exist between mumps infection in the mother during pregnancy and the appearance in infants of a disease called endocardial fibroelastosis. Doctor St. Geme in an interview said there is sufficient reason to consider mumps virus as a possible cause of the heart ailment which has baffled scientists for a long time.

Hemorrhage from a Granulosa-Theca Cell Tumor of the Ovary

(An Unusual Cause of Acute Abdominal Pain in a Child)

By M. A. LITTON, M.D. and E. W. LITTON, M.D., Rhinelander, Wisconsin, and T. C. FOX, M.D., Antigo, Wisconsin

■ THIS REPORT concerns a 3½-year-old girl whose preoperative diagnosis was acute appendicitis, but whose abdominal pain was caused by rupture of a cystic granulosa-theca cell tumor of the ovary with hemorrhage into the peritoneal cavity.

Case Report. A 3½-year-old white girl was admitted to the hospital at 4 PM with severe abdominal pain. She had been well until early the same morning when she seemed to have brief episodes of abdominal pain. When first examined at the physician's office at 2:30 PM, no history of nausea or vomiting was elicited, and she had had a normal bowel movement that morning. Abdominal pain was the only symptom. Careful review of the personal and family histories was noncontributory except that her paternal grandmother died of ovarian carcinoma at age 50 years.

On admission to the hospital, the patient appeared acutely ill. Pulse rate was 100 per minute and rectal temperature was 99 F. Generalized abdominal tenderness with apparent rebound tenderness and moderate abdominal distention were present. No bowel sounds were heard. Rectal examination revealed diffuse pelvic tenderness. The only other positive finding was slight enlargement of the breasts.

Laboratory studies showed a hemoglobin level of 8.9 gm/100 ml, hematocrit reading 26%, white blood cell count 11,950/cu mm with a differential of 83 segmented neutrophils, 15 lymphocytes, 1 eosinophil, and 1 monocyte. A 4+ acetone was the only abnormal urinary finding. The preoperative diagnosis was acute appendicitis, and the possibility that perforation had occurred between the office examination and hospital admission was considered. At operation the peritoneum transmitted bluish-red contents. Five hundred ml of fresh blood and clots were present in the peritoneal cavity. The appendix appeared normal. The left ovary was "lemon-sized" and the outer surface was gray-pink, smooth, and firm. The hemorrhage originated from a tear on the surface of the ovarian tumor. The right ovary was not enlarged and appeared normal. No other masses or evidence of tumor spread were seen. A left salpingo-oophorectomy and appendectomy were done. One unit of whole blood was given during the procedure. The patient's postoperative course was uneventful and she was discharged four days after surgery. She has been examined several times since the operation. The breasts are not enlarged and she appears to be in good health.

Pathologic Studies. The specimen was examined in the fresh state and consisted of an ovary, attached fallopian tube and the vermiform appendix. The ovary was round, 5.5 cm in diameter, with a gray-pink, firm, and smooth outer surface. The fallopian tube was stretched over the ovary. A slit-like tear was present on the surface of the ovary, 2.5 x 0.6 cm. Soft, gray-pink, and hemorrhagic tumor tissue and blood were present in the tear. This tear communicated with a centrally located cavity which was filled with fresh blood and clots. Gray-tan, firm nodular tumor tissue, up to 1.3 cm. in thickness, lined the cavity. Several cysts from 0.2 to 1.5 cm in diameter were present in the adjacent, compressed ovarian stroma. These cysts were filled with thin, clear fluid and the linings were smooth. The appendix was not remarkable. On microscopic examination of

the ovary the tumor tissue lined the large cyst. The tissue was composed of granulosa and theca cells. Mitoses were frequent. No evidence of luteinization was seen. There was slight pleomorphism of the tumor cells; however, this was not enough to warrant the diagnosis of carcinoma. The diagnosis was granulosa-theca cell tumor of left ovary with intraperitoneal hemorrhage secondary to rupture.

Comment. Although acute appendicitis is the commonest abdominal lesion necessitating prompt operation in children, many other disease processes may mimic acute appendicitis. Among these are ovarian tumors which may cause acute symptoms because of torsion or rupture and hemorrhage. Perry[1] reported a series of 35 children with ovarian tumors. Seven of the patients had solitary follicular cysts. In this group one of the cysts had ruptured, one was hemorrhagic and two had undergone torsion. In these four patients there were symptoms of lower abdominal pain, mild to moderate nausea and vomiting, and slight or no elevation of temperature. A preoperative diagnosis of acute appendicitis was made in these four patients. In another series[2] of 25 infants and children with ovarian tumors, torsion of the tumor occurred in five patients. The initial diagnoses in these five patients were acute

Fig. 1—Sectioned surface of cystic ovarian tumor and outer surface showing tear from which hemorrhage originated.

Fig. 2—High-power magnification of tumor, showing granulasa-theca type cells. (Hematoxylin-eosin stain X430.)

appendicitis in two, appendiceal abscess in one, and urinary bladder dysfunction in one. In one patient the preoperative diagnosis of torsion of an ovarian cyst was made. The authors stress the importance of abdominal pain of an acute or chronic nature, an enlarging abdomen, and abdominal mass in the diagnosis of torsion of an ovarian tumor.

The clinical picture of acute abdomen due to rupture and intra-abdominal hemorrhage from a granulosa-theca cell tumor is not often mentioned in the literature. In 1949, French[3] reviewed the literature and found a total of 25 cases of rupture with severe intra-abdominal hemorrhage, all in adults. He stated that he knew of three unreported cases. Von Friesen[4] reported seven cases of rupture with severe hemorrhage and commented that "rupture is more common in granulosa cell tumor than in any other type of ovarian neoplasm." We were unable to find a similar occurrence in a child in the recent literature, but do know of an unreported case of rupture and massive hemorrhage from a granulosa cell tumor in a 3-year-old child (Semba[5]). This child was admitted with an acute episode of vomiting, shock, and anemia. No hormonal manifestations of the tumor were present.

Granulosa-theca cell tumors constitute approximately 10 per cent of all solid tumors of the ovary.[6] The tumors may occur at any age; and of the total number reported, 5 per cent have occurred in children.[6] Signs of hormonal production are usually present and the tumors are frequently palpable. Granulosa-theca cell tumors may be very large and the gross appearance depends upon the degree of cystic change, luteinization, hemorrhage, and necrosis. The tumors are usually unilateral. It is often difficult to determine the degree of malignancy in these tumors from the microscopic appearance. Late recurrences[7] have been reported and for this reason these patients must have a prolonged follow-up.

Summary. An unusual cause of acute abdominal pain in a young child, namely rupture and intraperitoneal hemorrhage from a granulosa-theca cell tumor of the ovary, has been described.

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HOW WIDESPREAD IS THE USE OF MEASLES VACCINES?

It was reported in TIME, Feb. 19, 1965, that "only 7 million U. S. children have been vaccinated against measles, leaving 20 million susceptible youngsters". In line with this, the latest figures released by the National Disease and Therapeutic Index (N.D.T.I.), which is a nationwide survey of private medical practice,* indicate that physicians have given an estimated 8 million inoculations of measles vaccines since their introduction in 1963. Pediatricians account for 54% of this volume, GPs for 44%, and other specialties for the remaining 2%.

N.D.T.I. further reported that children under 10 years of age received 97% of all measles vaccine use—infants under 1 year account for 22%. Though teen-agers account for over 10% of measles visits, this age bracket is rarely given the vaccine.

Why aren't the currently available measles vaccines prescribed more widely? In subjective interviewing among some 400 physicians, it was learned that a substantial number of physicians (50%) do not consider measles serious enough to warrant immunization on the same basis as polio, diphtheria, tetanus, and smallpox. Survey results indicate that only 70% of physicians believe that all children under six should receive the vaccine—a reasonably large number still feel that children should acquire natural immunity from the disease itself. Questioned about the need for measles vaccination among adults, only 40% felt that the injections were indicated.

* Begun in 1955, N.D.T.I. was designed to meet a long recognized need for continuing and reliable statistical information about the patterns and treatment of disease encountered in private medical practice. Each year, 3000 randomly selected physicians use case record diaries to report basic diagnostic and therapeutic information about all patient contacts made by them during an assigned two-day period of practice.

Intrathoracic Complications of Staphylococcal Pneumonia in Infancy

Report of Three Cases, Two Requiring Lobectomy

By JAMES K. THEISEN, M.D., Green Bay, Wisconsin

■ INFANTS WITH staphylococcal pneumonia may develop tension pneumothorax requiring immediate closed drainage as a life-saving measure. Other intrathoracic complications include empyema, lung abscess, and bronchopleural fistula. Empyema usually responds to closed drainage and antibiotics, with or without intrapleural enzymes as demonstrated in Case 3. Lung abscess often responds to antibiotic therapy and residual pneumatoceles usually disappear in time, but it must be recognized that a sudden pneumothorax can occur at any time. Bronchopleural fistulae will often heal with prolonged drainage.

Collins et al.[1] reported 66 patients with lung abscesses, six of them under the age of 20 years. Medical therapy was carried out in 26 cases (39%), with two deaths, and surgical therapy in 40 (61%), with no deaths, although complications of bronchopleural fistulae (13 cases), all of which healed spontaneously, and empyema (3 cases) occurred. Of the 40 cases, resection was carried out in 32 patients. Moore[2] reported 18 postpneumonic pulmonary abscesses. Seven were treated medically in the preantibiotic era and all died. Four were treated with antibiotics; of these, two died. Seven were treated surgically, one with rib resection and drainage and six with lobectomy; all recovered.

Brain abscess or other complications leading to death occur frequently enough so that if the lung abscess does not respond in a reasonable period of time to conservative therapy, excisional therapy should be considered.

Sabiston et al.[3] reported 67 cases of staphylococcal pneumonia in infancy. There were five deaths. Four of the five were under three months of age and the three who had autopsy performed had lung abscesses.

Three cases are presented. Two failed to respond to conservative measures for treatment of lung abscess and were treated successfully by lobectomy. The third case represents the more common response to conservative therapy.

Case 1: A 3½-month-old white male infant was admitted to the hospital after having been treated with penicillin for ten days for an upper respiratory infection. Respirations were rapid and grunting. His pulse rate was 210 per minute; temperature was 104.5 F. There was subcutaneous edema and

Fig. 1—Case 1. Chest x-ray film on admission.

From St. Vincent Hospital.

Fig. 2—Case 1. Chest x-ray film, taken the day before surgery, showing a cavity in the right lower lobe.

redness over the right side of the chest wall. On admission the chest x-ray film revealed an opacity of the entire right hemithorax (Fig 1). Thoracentesis yielded thin cloudy fluid with chunks of fibrin. Closed intercostal drainage was established with a No. 16 Foley catheter with immediate release of 100 ml of thin cloudy fluid which yielded a coagulase-positive Staphylococcus organism on culture. The hematocrit reading was 31% and the white blood cell count (WBC) was 12,650/cu mm. Streptokinase and streptodornase were instilled intrapleurally along with 500,000 units of penicillin. Penicillin was started parenterally. The right lung sounds became distinct.

One day following admission the patient was given novobiocin and chloramphenicol. Two days later a chest x-ray film revealed the lung to be completely expanded. The following day another x-ray film revealed a radiolucent area adjacent to the cardiophrenic sulcus on the right side. The WBC was 27,600/cu mm. A third x-ray film,

Fig. 3—Case 1. Chest x-ray film on day of discharge.

taken three days later, revealed an abscess in the right lower lung field. The thoracotomy tube was removed. On the following day another x-ray film revealed a 20% pneumothorax with a radiolucent area in the right lower lobe (Fig 2). The next day there was increasing tension pneumothorax with nearly complete collapse of the right lung which did not respond to suction drainage.

Surgery was performed nine days following admission, because of the presence of a bronchopleural fistula. A lobectomy of the right lower lobe was carried out with decortication of the upper and middle lobes. There was extensive destruction of tissue of the basilar segments of the lower lobe of the right lung with a large air leak on the diaphragmatic surface and a smaller leak on the anterolateral surface. The superior segment of the lobe was not involved. Examination of the specimen revealed the ruptured abscess cavity to be in communication with the anteromedial segment of the lower lobe bronchus. Two intercostal catheters were used to provide postoperative underwater seal drainage. Penicillin and streptomycin were instilled intrapleurally on each of the first four postoperative days.

The upper thoracotomy tube was removed on the fourth postoperative day and on the following day constant suction was applied to the lower tube because of a persistent air leak which then rapidly ceased. The lower thoracotomy tube was removed on the seventh postoperative day. The patient was discharged on the 15th postoperative day when

Fig. 4—Case 2. Chest x-ray film, taken the day of surgery, revealing two cavities in the upper lobe.

a chest x-ray film revealed good expansion of the remaining right lung with a slight residual pleural thickening (Fig 3).

Case 2: A 20-month-old male infant was admitted to the hospital because of recurring fever and mild respiratory infection of several weeks duration. He had sustained an electrical burn to the mouth a month earlier, with subsequent occurrence of frequent convulsions which were controlled with anticonvulsants. On the ninth day following admission he developed an agranulocytosis. The WBC was 7,190/cu mm with a differential count of 94 lymphocytes and 6 monocytes. Electroencephalograms taken a month prior to admission and again five days after admission were abnormal. The anticonvulsants were discontinued with correction of the agranulocytosis and no recurrence of convulsions. Physical examination had revealed bronchial-type breath sounds on the right and a deforming scar of the upper lip. No other abnormalities were present. Chest x-ray films revealed persistent consolidation of the right upper lobe. A radiolucent zone suggesting the presence of a small abscess was noted on some of the films, and three days before admission a chest x-ray film revealed two cavities at the apex with honeycombing lower in the upper lobe.

Thoracentesis, ten days after admission, yielded a small amount of serous fluid which was negative on culture. Throughout the infant's hospitalization there was frequent spiking of his temperature to as high as 105 F, which did not respond to antibiotics. Three weeks following admission a throat culture yielded a coagulase-positive Staphylococcus organism and Group A Streptococcus organism. The infant had intensive chemo-

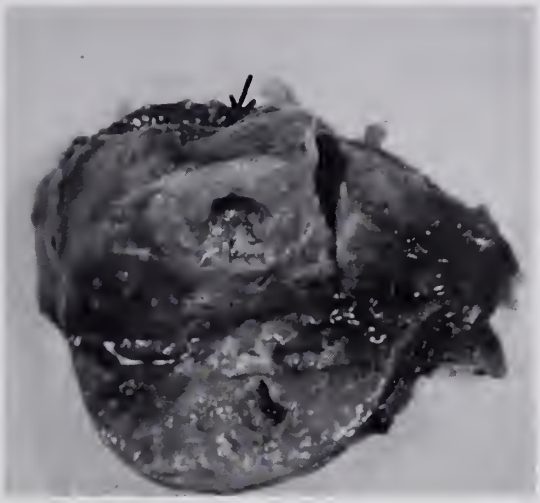

Fig. 5—Case 2. Cut surface of the right upper lobe revealing large abscess cavity. Arrow points to second abscess cavity at the extreme apex which was opened during removal of the lobe. The two abscess cavities communicated.

therapy for ten days, including courses of oxytetracycline, penicillin, erythromycin, and streptomycin.

Surgery was performed one month after admission. A preoperative chest x-ray film revealed persistence of the two cavities in the upper lobe (Fig 4). A thick fibrin peel over the entire lung was very adherent, but only loosely adherent to the parietal pleura. A decortication of the middle and lower lobes allowed adequate expansion and marked improvement in aeration of the lobes. An upper lobectomy was also performed. The lobe contained two thick-walled abscesses which were filled with thick purulent material (Fig 5).

Culture of this yielded coagulase-positive staphylococcal organisms sensitive to novobiocin, erythromycin, neomycin, and chloramphenicol. A No. 16 Foley catheter was used to drain the dependent posterior region, and a No. 14 Foley catheter was used to drain the apex of the pleural space. Both catheters were connected by means of a "Y" tube to underwater seal drainage. Neomycin (100 mg), streptomycin (250 mg), and penicillin (600,000 units) were instilled intrapleurally. Auscultation revealed good aeration of both lungs immediately postoperatively. The pathologic diagnosis was: subacute, multilocular abscesses with organized fibrinous pleural exudate and focal abscesses in the regional lymph nodes. A chest x-ray film, taken on the first postoperative day, revealed the right lung to be

Fig. 6—Case 2. Chest x-ray film taken five months postoperatively.

Fig. 7—Case 3. Chest x-ray film taken one week after admission, showing large pneumatocele.

fully expanded. Postoperatively the child was given penicillin and chloramphenicol. Sodium methicillin was added two weeks postoperatively. The upper thoracotomy tube was removed the second postoperative day and the lower one on the third postoperative day. The highest postoperative temperature was 100.4 F on the 11th day, one day prior to instillation of sodium methicillin. The child was released from the hospital on the 16th postoperative day and maintained on sodium oxacillin for one week. A chest x-ray film taken five months postoperatively was normal (Fig 6).

Case 3: A 4-month-old white female infant was admitted to the hospital for treatment of pneumonitis on the left side. Her temperature was 104 F, hemoglobin level 10 gm/100 ml, and WBC 31,000/cu mm with a differential count of 78 segmented cells, 12 band forms, 7 lymphocytes, and 3 monocytes. She was treated with penicillin and tetracycline. Her temperature returned to normal the day after admission, but gradually rose to 102 F on the fourth day. Subsequently there was daily spiking of the temperature to 102 F until the ninth day when it returned to normal. A chest x-ray film, taken the day after admission, revealed an opacity over the entire left hemithorax. A chest x-ray film a week later revealed a large pneumatocele involving the lower half of the left hemithorax with considerable collapse of the left lung (Fig 7).

Thoracentesis a week after admission yielded purulent material which grew a Staphylococcus organism sensitive to penicillin and novobiocin. A No. 16 soft rubber catheter was inserted. After evacuation of thick creamy purulent material, 20,000 units of streptokinase, 5,000 units of streptodornase and 500,000 units of penicillin were introduced into the pleural space and the tube clamped but connected to an underwater seal drainage bottle. The patient was observed carefully for signs of respiratory difficulty and after six hours the clamp was released with evacuation of a considerable amount of thin purulent material and active bubbling of air for a short while.

A chest x-ray film two weeks after admission revealed the lung to be fully expanded (Fig 8). The tube was removed three days later and the patient was discharged on the 19th postoperative day.

Fig. 8—Case 3. Chest x-ray film taken two weeks after admission.

Summary. Early intensive therapy with antibiotics and intercostal tube drainage, when indicated for the complications of staphylococcal pneumonia in infants, will usually obviate the necessity for more extensive surgical treatment. When excisional therapy appears indicated, it should be carried out without undue delay. Three cases have been presented to illustrate the complications most often encountered: Case 1—Bronchopleural fistula from spontaneous rupture of a lung abscess; Case 2—Persistent lung abscess; and Case 3—Pneumatocele with pyopneumothorax.

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EARLY DETECTION OF EAR DISORDERS

"Early detection of a conductive hearing loss enables prevention of further impairment in most cases. Modern microsurgical techniques offer correction of most conductive hearing losses regardless of the cause."

So state Howard P. House, M. D., Fred H. Linthicum, Jr., M. D., and E. W. Johnson, Ph. D., three leading hearing specialists, writing in the AMERICAN JOURNAL OF DISEASES OF CHILDREN, December 1964.

Repeatedly, they stress the importance of diagnosing and treating ear diseases early—before they progress too far. Their survey of the major kinds of hearing impairment and treatment procedures for children leads the three experts also to conclude that:

"Great advances have been made during the past decade in testing procedures, hearing aids, and in the medical and surgical treatment of the hearing handicapped."

Less bright, however, is the situation Doctors House, Linthicum and Johnson describe with regard to nerve and perceptive hearing impairments. These, the writers say, "are for the most part not preventable or correctable by medical or surgical means." They point out, however, that "rehabilitative measures including the use of accurately fitted hearing aids, auditory training, lip reading and speech therapy will in most cases enable the hard-of-hearing child to take his normal place in society."

What are the prospects for research progress in inner ear and other disorders?

The authors conclude that: "Through continued research efforts, it is our fond hope that the sensorineural sound barrier will be broken so that all may soon enjoy the privilege of good hearing."

To speed that day, The Deafness Research Foundation, the only national voluntary health organization devoted primarily to furthering research into the causes, treatment and prevention of hearing impairment and other ear disorders, has helped mobilize the nation's medical resources in a broad frontal attack on deafness.

The eventual prevention of many forms of deafness depends on making available to medical researchers adequate supplies of impaired inner ear structures. That is why The Deafness Research Foundation is making an urgent appeal for assistance from the deaf and hard of hearing—the only people who can provide doctors with the answers they need about the disorders of the inner ear.

On June 30, 1960, The Deafness Research Foundation launched the Temporal Bone Banks Program for Ear Research in cooperation with the American Academy of Ophthalmology and Otolaryngology to provide medical researchers with inner ear structures for study.

During the five years since, there has grown a network of more than three dozen ear "banks" throughout the United States.

Temporal Bone Banks are research laboratories where bequeathed inner ear structures are studied together with the donors' medical and hearing records.

To maintain completed pledge forms and medical histories of those who bequeath their inner ear structures to the Temporal Bone Banks Program, The Deafness Research Foundation has established four Regional Temporal Bone Banks Centers.

The Regional Centers are: a Western Center at the University of California, San Francisco Medical Center, San Francisco, California; an Eastern Center at Johns Hopkins Hospital, Baltimore, Maryland; a Southern Center at Baylor University, Houston, Texas; and a Midwestern Center at University of Chicago, Chicago, Illinois.

The Centers also coordinate the acquisition, distribution and medical documentation of the bequeathed ear structures following the death of the donor.

The Temporal Bone Banks Program, though still in its infancy, is recognized as a highly significant development for otologic research. Its ultimate success will depend upon hearing impaired Americans making available to scientists thousands of inner ear structures accompanied by their medical and hearing records.

CASE REPORT

"Cat-Scratch" Disease

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■ "CAT-SCRATCH" disease is a benign, subacute, regional lymphadenitis which may proceed to sterile suppuration or subside spontaneously. An indolent primary skin lesion at the site of a cat scratch precedes the adenitis.[2] Children are affected more frequently than adults. Most victims are scratched by a cat and few are bitten. The following case report is thought to illustrate an infection through an open wound occurring while the patient was in contact with cats, but apparently without being scratched by them.

The causative agent has not been isolated.[3] Complement fixation reactions to lygranum CF are without diagnostic value and afford no convincing evidence that the disease belongs to the psittacosis-lymphogranuloma group of diseases.

Case Report. A 4-year-old boy was bitten by his brother at play on Oct. 21, 1964. The bite was on the right cheek and it subsequently developed a large hematoma beneath the intact skin. This persisted until November 3 when it was drained through an incision in the right cheek, and a large cavity was evacuated of old liquid blood. In the week following this incision and drainage of the hematoma, the patient was in contact with three cats and kittens for a period of several days during which he handled the animals repeatedly. The wound on the cheek closed and shortly thereafter enlarged, tender lymph nodes developed along the inferior portion of the right mandible and in the anterior cervical region. One of these glands broke down and a draining sinus tract developed near the angle of the mandible.

The patient entered the hospital Jan. 12, 1965. At the time of admission, his temperature was 100 F, pulse rate 112, and respirations 20. Blood studies showed a hemoglobin level of 12.2 gm/100 ml, hematocrit 38%, white blood cell count 13,800/cu mm with 53 segmented cells, 42 lymphocytes, 4 eosinophils, and 1 basophil. Urinalysis was negative for sugar and albumin.

The following day an incision was made under the patient's chin and four large glands were excised. Free pus was exuding from one of them. The small skin sinus was also resected. The skin was closed loosely with five dermal sutures. A rubber tissue drain was placed in the wound.

Pathologic Report. On gross examination the specimen consisted of submaxillary and cervical lymph nodes which ranged in size from 1 to 2 cm. There were three identifiable nodes and also small pads of indurated fat. Each of these nodes contained a central area of necrosis. Additional specimens consisted of soft, pale salivary gland tissue in an oblong, lobulated mass which measured 3.5 x 3.2 x 2.5 cm.

Microscopic studies showed that multiple sections of the cervical lymph nodes were essentially similar and all showed a distinctive pattern of a central stellate area filled with amphophilic debris which was surrounded by a bright eosinophilic necrotic margin which in turn was surrounded by epithelioid cells. These radiated from the center of these curiously angulated zones of necrosis. Peripherally, there were a few clusters of lymphocytes with small germinal centers. The capsules were thick and fibrous. This pattern was duplicated in all of the sections examined. Scattered throughout the tissue were occasional giant cells reminiscent of tuberculosis, but they were not of a uniform pattern nor did they have the usual number of nuclei. Sections of the salivary gland showed well differentiated acini, ducts, and septa. No significant pathology was noted in the salivary tissue submitted.

Diagnosis. (1) "Cat-scratch" disease in submandibular and cervical lymph nodes. (2) Salivary gland tissue.

Clinical Course. The patient's temperature became normal in three days and he made an uneventful recovery. The drainage stopped completely and the child left the hospital on the ninth postoperative day. Bacteriological fungus cultures and smears were all negative.

continued on page 291

PEDIATRICS ACADEMY URGES ROUTINE IMMUNIZATION OF ALL CHILDREN WITH MEASLES VACCINE

Routine immunization of all children with measles vaccine has been urged by the American Academy of Pediatrics. The Academy's Committee on the Control of Infectious Diseases in a statement in the May issue of the Academy's News Letter said: "Measles can be the next infectious disease to be eliminated from the United States if the presently available vaccines are widely used.

"The vaccines are safe and effective, production problems have been solved, and six competitive vaccines are now commercially available and are approved and licensed by the Division of Biologic Standards of the U. S. Public Health Service."

The Committee endorsed the five immunization schedules outlined by the U. S. Public Health Service Advisory Committee on Immunization Practices. These include live attenuated vaccine, live attenuated vaccine plus measles immune globulin, live, further attenuated vaccine, inactivated vaccine, and inactivated vaccine followed by live attenuated vaccine. (The PHS-recommended dosage schedule is printed below.)

The Committee urged "all physicians and public health personnel to take whatever steps are necessary to see that all susceptible children receive measles vaccine. Vigorous endorsement and execution of this aim by physicians and responsible authorities should eliminate measles by 1970."

Measles vaccine should be administered routinely to all children without a history of clinical measles or measles vaccination, the Committee said. It did not recommend mass community immunization programs in the United States.

It also cited the need for immunization for those children especially prone to develop serious complications from measles. These include children in institutions, and those with heart disease, cystic fibrosis, tuberculosis, asthma, and other chronic pulmonary disease.

Dosage Schedules for Measles Vaccines

Schedule	Type of Vaccine	Age	Doses* and Administration	Comment
1	Live, Attenuated Vaccine	12 months and older	1	Although the live attenuated vaccine may be administered safely with or without the simultaneous administration of Measles Immune Globulin most physicians will wish to use the two combined because of the lessened frequency of clinical reactions.
2	Live, Attenuated Vaccine plus Measles Immune Globulin	12 months and older	1 plus Measles Immune Globulin (.01 cc per pound at different site with different syringe)	The live attenuated vaccines should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children.
3	Live, "Further Attenuated Vaccine"	12 months and older	1	Clinical reactions following the "Further Attenuated Vaccine" are relatively infrequent; Measles Immune Globulin is not necessary with this Vaccine.
4	Inactivated Vaccine	Any age	3† (monthly intervals) plus a booster dose after one year	In view of the rapid fall-off in antibody and evidence of decreasing immunity following a primary immunization series, use of this vaccine is not preferred except for special groups in which live attenuated vaccine is contraindicated. The degree and duration of protection which might be afforded to those given a booster has not yet been determined.
5	Inactivated Vaccine followed by Live, Attenuated Vaccine	12 months and older	1 dose inactivated vaccine followed in 1 to 3 months by 1 dose live attenuated vaccine	The preceding administration of inactivated vaccine serves to reduce the frequency and severity of clinical reactions following live attenuated vaccine administration.
		Under 12 months	3 doses inactivated vaccine at monthly intervals followed by 1 dose live attenuated vaccine at 12 months of age or older	The live attenuated vaccine should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children.

*Manufacturers' directions regarding volume of dose should be followed.
†In view of rapidly declining antibody levels and protection, at least one booster dose about a year later is necessary. Data are not yet available to indicate when or with what frequency additional booster doses might be required.

CAT-SCRATCH DISEASE *continued from page 290*

Conclusion. "Cat-scratch" disease may last two weeks to two years. Removal of suppurative nodes and drainage usually clear up the condition, but resolution may occur spontaneously. Surgery is indicated for diagnosis.

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Treatment of Urinary Tract Infections in Children

By JAMES D. CHERRY, M.D.
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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

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■ URINARY TRACT INFECTIONS in children are second in frequency only to infections of the respiratory tract.[1] Despite this frequency there are large gaps in knowledge of the pathogenesis; as a consequence, therapeutic results are far from optimal. The ravages of chronic pyelonephritis offer one of the major preventive medicine challenges of the future. The purpose of this communication is to review, in light of recent knowledge, pediatric aspects of the management of urinary tract infections.

Principles of Therapy. Principles that underlie therapy of urinary tract infections are recorded in Table 1. It should be emphasized that a significant number of asymptomatic, apparently healthy children have urinary tract infections.[2] Because of this, routine examination of the urine for bacteriuria should be included in the office evaluation of pediatric patients. Also to be emphasized is that the only satisfactory method for the establishment of the diagnosis of urinary tract infection is the demonstration of bacteriuria.

Clinical Management. The single most important aspect in the management of urinary tract infection is the need for continuous long-term urinary bacteriologic follow-up. A stepwise outline for the management of childhood urinary tract infections is recorded in Table 2, and selected therapeutic agents are listed in Table 3.

From the John A. Hartford Research Laboratory, Madison General Hospital and the Department of Pediatrics, University of Wisconsin Medical School. Supported in part by the John A. Hartford Foundation, Inc.

Doctor Cherry is Assistant Professor of Pediatrics, University of Wisconsin Medical School; Director, John A. Hartford Research Laboratory; and a Markle Scholar in Academic Medicine.

TABLE 1—*Principles That Underlie Therapy of Urinary Tract Infections*

1. The majority of urinary tract infections are probably the result of retrograde travel of bacteria to the bladder. The mechanism is unknown.
2. Infection is frequently associated with obstructive lesions of the urinary tract.
3. Boys rarely ever have infection without associated obstruction. How and why bacteria arrive above the point of obstruction is unknown.
4. Girls often have infection without demonstrable obstruction.
5. Urinary tract infection frequently occurs without clinical signs or symptoms and, therefore, routine examinations of the urine for bacteriuria should be performed at well-child checkups.
6. The kidneys may be involved even though symptoms are localized to the lower urinary tract.
7. Therapy that adequately controls bacteriuria will usually permit the kidney to rid itself of bacteria.
8. Bacteriuria can occur without pyuria.
9. Pyuria can occur without infection.
10. If pyuria is used as the sole criterion for diagnosis, many patients without infection will be treated and many patients with infection will be missed.
11. Urine for culture collected by conventional methods (clean, voided, midstream specimen) is easily contaminated during collection.
13. The urinary bacterial colony count enables the differentiation of collection contamination from true bacteriuria. (Specimens for colony counts must be refrigerated until processed.)
14. Colony counts $\geq$ 100,000 bacteria per milliliter usually indicate true bacteriuria. Specimens contaminated during collection usually have counts $<$ 10,000 bacteria per milliliter. Counts between 10,000 and 100,000 bacteria per milliliter should be repeated. (These values are for a standard pour-plate technique[3] and do not necessarily apply to other methods.)
15. The microscopic examination of the urine is a simple, reliable method for detecting bacteriuria due to rod-shaped organisms. If organisms are seen in each high-power field (430X), the colony count is $>$10,000 bacteria per milliliter and usually $>$ 100,000 bacteria per milliliter.
16. The only satisfactory method for the diagnosis of urinary tract infection is the demonstration of bacteriuria.

TABLE 2—*Management of Urinary Tract Infections in Children*

A. Initial Infection in a Boy
1. Treat with a sulfonamide for two weeks.
2. Examine urine two days after onset of therapy. If bacteria are still present, change therapy on basis of *in vitro* sensitivity results.
3. Careful urologic investigation should be performed.
4. Abnormalities of the urinary tract should be surgically corrected.

B. Initial Infection in a Girl
1. See steps A1 and A2.
2. Examine for bacteriuria one week, one month, six months, and one year after conclusion of antimicrobial therapy.
3. Urologic investigation is not necessary if the patient is followed closely (step B2) and there is no suggestion of obstruction. (Many authorities recommend obtaining an IVP with the first infection.)

C. Second Infection
1. See steps A1, A2, and B2.
2. Obtain an IVP. If an abnormality is noted on the IVP, do a complete urologic investigation, including a voiding cystourethrogram.

D. Recurrent Infections
1. See Steps A3 and A4.
2. Treat on the basis of *in vitro* sensitivity tests for two weeks, and then change to long-term (6 mo. to 1 yr.) prophylactic therapy with a sulfonamide, nitrofurantoin, or acidification and methenamine mandelate.

E. Chronic Infection with Renal Damage
1. See steps A3 and A4.
2. See step D2, but initially use high dose therapy for 4 to 8 weeks.

F. Patients Who Need Indwelling Catheter
1. Do not administer systemic antibiotics.
2. Use a three-way indwelling catheter with a constant bladder rinse with either 0.25% acetic acid or neomycin-polymyxin saline solution (40 μg/ml neomycin and 20 μg/ml polymyxin).[4]

TABLE 3—*Specific Therapeutic Agents*[5-7]*

Drug	Dose	Specific Recommendations and Comments
Sulfisoxazole† (Gantrisin)	75 mg/kg initially; then 150 mg/kg/day administered every 6 hr (not over 5 gm/day). One half this dose for long-term therapy.	1. Initial therapy for all Gram-negative rod infections. 2. *In vitro* sensitivities frequently not reliable.
Nitrofurantoin (Furadantin)	5 to 8 mg/kg/day, every 6 hr (not over 400 mg/day). One-half to ¼ of this dose for long-term therapy.	1. Usually adequate therapy for initial infections. 2. Blood level is insignificant so should not be used when tissue level desired.
Tetracycline	20 to 30 mg/kg/day, every 6 to 8 hr.	Should only be used when indicated by sensitivities and in situations where tissue levels of antibiotics are desired.
Chloramphenicol	50 to 100 mg/kg/day, every 6 to 8 hr. (Premature and newborn infants 25 mg/kg/day).	Same as tetracycline.
Penicillins: Penicillin G, V; Ampicillin	250 mg to 1 gm every 4 to 6 hr.	Can be used for certain relatively sensitive Gram-negative rods (Proteus mirabilis; others). Large doses usually necessary.
Combination of penicillin and streptomycin	Penicillin 250 mg to 1 gm every 4 to 6 hr. Streptomycin 20 to 40 mg/kg/day, every 12 hr (not over 1 gm/day).	Specific for the treatment of enterococcal infection regardless of sensitivity results.
Combination of methenamine mandelate (Mandelamine) and either ascorbic acid or methionine.	Mandelamine 50 to 100 mg/kg/day, every 8 hr (not over 3 gm/day) and either methionine 200 mg/kg/day or ascorbic acid 50 mg/kg/day every 8 hr. (The dosage of methionine or ascorbic acid should be gradually increased until the urine pH is consistently below 5.5).	Can be used for long-term prophylactic therapy. To be successful the urinary pH must be maintained below 5.5.
Other: kanamycin, polymycin B, colistin, Gentamicin	See specific literature.	Because of toxicity should only be used in selected cases when other drugs are not effective and when indicated by *in vitro* sensitivities.

*Drug literature should be observed for specific toxicities and precautions.

†Many other sulfonamides are equally effective.

continued on page 299

CLINICOPATHOLOGIC CONFERENCE

P C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: J. M. B. BLOODWORTH, JR., M.D.

Madison, Wisconsin

Dr. J. M. B. Bloodworth, Jr.: This case represents a problem in the diagnosis of the acute abdomen, and because it is a CPC you may expect an unusual problem in addition. We have purposely withheld the details of surgery and some other information not available to the clinician until after death. I have asked Doctor Gott to discuss the case on this basis, following which we will present the findings at surgery and some additional x-ray findings. In this way I hope to promote a discussion of the commonplace before we enter the realm of the exotic. I firmly believe that an exercise intended primarily for medical students should never over-emphasize the unusual.

Case Presentation:* A 42-year-old white male mechanic was admitted to the hospital for the first time with a chief complaint of paresthesia of the lower extremities, presumably due to an episode of frostbite that occurred 19 years before admission. Paresthesia was present during the years immediately following the frostbite, extending only to the ankles. Three weeks before admission the patient noted an exacerbation of paresthesia extending up to the knee and associated with sharp pains. He also noted dependent lividity of the same areas of the legs upon extended standing. A few hours prior to admission, on the way to the hospital for elective evaluation of the paresthesia, the patient ate a hamburger, following which he developed mild, generalized abdominal pains.

History revealed fracture of the left femur when the patient was a child. He stated that he smoked one pack of cigarettes daily and consumed a modest amount of alcohol. Except for the complaints leading to admission, the history was negative for cardiovascular, respiratory, gastrointestinal, and genitourinary symptoms.

On admission physical examination in the admitting room revealed a temperature of 97.6 F, pulse rate 80, respirations 20, and blood pressure 190/100 mm Hg. The patient was a well developed, obese, somewhat deaf, well oriented, adult male. Examination of the heart revealed a grade 3 crescendo, late systolic murmur heard best over the apex and the left sternal border. The lungs were clear. Abdomen was negative to palpation and free of tenderness.

Examination of the extremities revealed long-standing deformities of the toes, erythema, and mild tenderness of the feet. Pulses were present in both feet, the right greater than the left. Gross neurologic examination revealed only a decrease in sensation to pin-prick below the knees and some increase in reflexes of the extremities.

On admission laboratory studies revealed the following values: blood urea nitrogen (BUN) 9 and blood sugar 226 mg/100 ml; negative urinalysis; white blood cell count (WBC) 16,200/cu mm with a differential count of 91% neutrophils; hematocrit 53.5%; and hemoglobin 17.0 gm/100 ml.

The patient was admitted at 11 PM. The first blood pressure recorded on the ward was 230/128 mm Hg. During the first night, the abdominal pain became progressively worse, and there were several episodes of nausea and vomiting. During this period he was given prochlorperazine (Compazine) and secobarbital sodium (Seconal). His blood pressure the next morning, 10 hours after admission, was 80/62. A clinical syndrome of shock developed and the patient was given oxygen.

During the first hospital day, the abdomen became acutely tender and distended. Intestinal sounds were absent. Symptoms of shock persisted with thready pulse. X-ray studies in the afternoon revealed distention of both large and small intestines, and gas in the upper abdominal area, thought to be present in the free abdominal cavity as well as the biliary tree. A Levin tube was passed and reddish fluid was suctioned from the intestine. A repeat WBC was 22,000/cu mm.

* From Madison Veterans Administration Hospital, presented as a CPC at University Hospitals.

Despite intravenous fluids and blood transfusion, the patient continued in shock and late in the afternoon of the first hospital day an exploratory laparotomy was done. Definitive surgery was impossible and the abdomen was closed. The patient died on the evening of the first hospital day, several hours after surgery.

Clinical Discussion. *Dr. Vincent Gott:* First, I would like to touch on a few of the high points in the history. The age of this 42-year-old man is certainly important in the consideration of the differential diagnosis later. He had a history of frostbite and paresthesia from the ankle down immediately after the frostbite, then three weeks prior to admission he developed fairly severe paresthesia from the knee downward and dependent lividity on standing, in the same area. He ate a hamburger on the way to the hospital, which was followed by mild abdominal pain.

On admission his chief complaints were paresthesia below the knees and mild abdominal pain. He was reported to consume a modest amount of alcohol. It is certainly important that his past history was negative for cardiovascular, respiratory, gastrointestinal, and genitourinary pathology. He was afebrile with fairly normal pulse and respiration; he had quite marked hypertension with fairly high diastolic pressure, and was obese.

We note he had grade 3 crescendo cardiac systolic murmur, heard best over the apex and to the left of the sternum. In this location it would be unusual for it to be the murmur of aortic stenosis; and certainly with this blood pressure of 190/110, it would be unusual for him to have aortic stenosis. It is not the typical murmur for mitral insufficiency. I suppose he could have a ventricular-septal defect causing a murmur of this type, with a grade 3 crescendo systolic murmur heard best over the apex in the left sternal border. I am not sure at the moment just what the lesion would be to cause this particular murmur. Pulses were present in both feet, the right greater than the left. It is interesting that his blood sugar was 226 mg/100 ml, his WBC was elevated, and he had a polycythemic condition with a high hemoglobin level, which may be important in the etiology of his abdominal problem.

He was admitted at 11 PM. His blood pressure was even higher when recorded later on the ward, and we note that during the first night he had a change in his abdominal symptoms with nausea, vomiting, marked tenderness, and pain. The following morning there was evidence of a shock-like condition. In 10 hours, some condition in the abdomen had progressed very, very rapidly, and this may make our differential diagnosis a little easier. We note, too, that his abdomen was distended, intestinal sounds were absent, and he had a "shocky" condition. We note that the x-ray films were thought to show distention of both the large and small intestines, and apparently there was some free gas in the upper abdominal cavity as well as in the biliary tree. It is noted that he had an exploratory laparotomy.

We apparently have a case of intestinal obstruction with evidence of air in the large and small intestines, possible free air in the abdominal cavity, and air in the biliary tract. These are all very interesting findings; certainly the free air in the abdominal cavity would suggest a perforation.

TABLE 1—*Differential Diagnosis of Intestinal Obstruction*

1. *Mechanical Obstruction*
   - (a) Narrowing of intestinal lumen
     1. Malignancy
     2. Inflammation
     3. Gallstone ileus (likely to cause free air)
   - (b) Bands and adhesions
   - (c) Strangulation of intestine
     1. Hernia
     2. Volvulus
     3. Intussusception
2. *Nervous Imbalance*
   - (a) Paralytic ileus simple
   - (b) Spastic ileus, simple
3. *Vascular Obstruction*
   - (a) Mesenteric artery occlusion
     1. Embolus
     2. Arteriosclerosis (with thrombus)
   - (b) Mesenteric venous occlusion

The three broad categories of intestinal obstruction include mechanical obstruction, nervous imbalance, and vascular obstruction. In the area of mechanical obstruction, we can have narrowing of the intestinal lumen caused by a malignancy, inflammation, or in rare cases, by a gallstone which has ruptured into the intestine. I mention this latter type of obstruction since it is accompanied by air in the biliary tree such as was seen in this case. There is no suggestion of a gallstone in the small intestine in this case,

however; and he appears to have vascular compromise of the intestine which would be unusual with gallstone ileus.

Completing the category of etiologic factors causing mechanical obstruction, there are adhesions, hernia, volvulus, and intussusception. Since this case appears to represent a strangulation-type of obstruction rather than a simple obstruction, only the last three types mentioned could be considered. For this same reason, the obstruction caused by nervous imbalance (category 2) can be ruled out. The third and final category is that of vascular obstruction, either arterial or venous. Considering the rapid onset of this obstructive picture, most likely we will find a vascular problem here; and the basic problem could be an embolus to the superior mesenteric artery—possibly from his heart.

It is still necessary to explain the air in the biliary tract and the questionable free air in the upper peritoneal cavity. This most likely can be explained by the presence of the pathologic entity called pneumatosis cystoides intestinalis.[1] In this condition there is free air or gas in the wall of the intestine and frequently in the biliary tree. Also, this gas in the intestinal wall can give the appearance of free air in the peritoneal cavity. This condition is quite rare and there have been only a few cases reported. The presence of the gas can be from several factors, including traumatic and infectious causes.

In conclusion, I think the basic problem is a vascular accident involving the mesenteric vessels. I think there is most likely an embolus to the superior mesenteric artery. There may be a concomitant pneumatosis cystoides intestinalis.

Dr. John Morrissey (gastroenterologist): I was very pleased to hear Doctor Gott's discussion. I think he covered the problem extremely well. I have relatively little to add and tend to go along with his impression. I believe there is a notation in the chart that the patient's blood sugar was somewhat elevated, and that the blood pressure was also elevated. A diagnosis of diabetes with hypertension would explain the presence of severe vascular disease at the relatively young age of 42 years.

I think the most specific finding, if valid, is the presence of air in the biliary tree. This is an unusual occurrence and helps us to rule out a number of causes of intestinal obstruction. Neither a mechanical nor paralytic ileus could explain the presence of air in the biliary tree. Air is usually found in the biliary tree only when there is a break in the integrity of the ampulla of Vater. Such a rupture may be produced by passage of a gallstone, as mentioned by Doctor Gott, from the bile duct into the intestinal tract along an abnormal communication between the intestinal tract and the biliary tree. The rupture can also occur from the common duct through the ampulla into the duodenum.

A more rare situation would be a perforation of a peptic ulcer in the opposite direction from the duodenum into the biliary tree. This would be an alternative possibility. Another mechanism could be a clostridium septicemia. Occasionally, the organism involved in an infection within the biliary tree may be the clostridium organism. Thus, a possible explanation would be a clostridial cholecystitis. Another possibility, which doesn't fit quite so well, is an ileus which may rarely be accompanied by infection with enteric organisms. Typhoid fever or salmonellosis in a fulminating form could produce this picture without diarrhea. Often diarrhea is not present in overwhelming infection with intestinal organisms. If I wasn't tipped off that this is something exotic, I would be inclined to go along with Doctor Gott; namely, that this was basically a vascular problem. To throw in a different diagnosis, I postulate that this was a clostridial infection in the biliary tree.

Doctor Bloodworth: This case was presented as it unfolded to the clinicians while the patient was actually being treated. Deterioration was so rapid that the x-ray films were taken on an emergency basis and surgery was done almost immediately—prior to the formal reading of the films by the roentgenologist. Surgery was, therefore, performed on the basis of the clinical picture and x-ray studies, which were interpreted only to indicate the presence of air in the upper abdomen, probably in the biliary tree.

At surgery, the entire small intestine, except for a few cm of duodenum and approximately half the colon, were dark reddish-black and thought to be gangrenous. The patient was considered inoperable in view of the extent of the gangrene and the poor status of the patient, who was in borderline shock. Therefore, a culture of the peritoneal fluid was obtained and the abdomen was closed. The culture, reported after death, re-

Fig. 1—X-ray film of abdomen taken shortly before surgery. Over the liver area (upper arrow) there are linear, branching gas shadows which extend to the periphery of the liver. This appearance is pathognomonic of gas in the portal venous system. There is a modest gaseous distention of both small intestine and colon. At the lower arrow there is a small, dark line thought to represent gaseous dissection in the wall of a loop of edematous small intestine.

vealed Streptococcus faecalis, Klebsiella aerobacter and Clostridium welchii.

Dr. Andrew B. Crummy: Supine films of the abdomen and chest are available for interpretation. The striking findings are on the abdominal film (Fig 1). In the right upper quadrant, in the region of the liver, linear branching gas shadows can be seen. These extend to the periphery of the liver and the appearance is pathognomonic of air in the portal venous system.[2]

Gas outlines most of the small intestine and colon. These structures are not greatly distended and the picture is that of paralytic ileus. The wall of some of the loops of the small intestine in the region of the pelvis appears to be outlined by gas on both sides, which raises the question of pneumatosis cystoides intestinalis.

No evidence of pneumothorax or pneumomediastinum can be seen. This is an important observation because there is evidence to show that the air in the intestinal wall in "pneumatosis" is a result of dissection down from the thorax through the mesentery into the intestinal wall.

The distinction between gas in the biliary tree and gas in the portal venous system is based on the distribution of the gas. The portal vein gas will extend to the margin of the liver while that in the biliary tree is usually more centrally located in the region of the liver hilum. In virtually all reported cases of portal venous gas demonstrated by x-ray, the underlying condition has been intestinal necrosis. The major condition leading to such necrosis is a vascular accident.

It is important to distinguish between biliary gas and portal venous gas. Biliary tract gas may be seen in asymptomatic patients after sphincterotomy. It also may be seen in "gallstone ileus," a condition requiring surgery. Portal vein gas with the underlying intestinal necrosis is almost uniformly fatal.

Fig. 2—Photomicrograph of approximately one-fourth the cross-section area of the superior mesenteric artery. The original level of the intima is indicated by the arrows. An organized thrombus (T) has obliterated 90 to 95 per cent of the lumen. A small residual lumen (L) is apparent. X 37

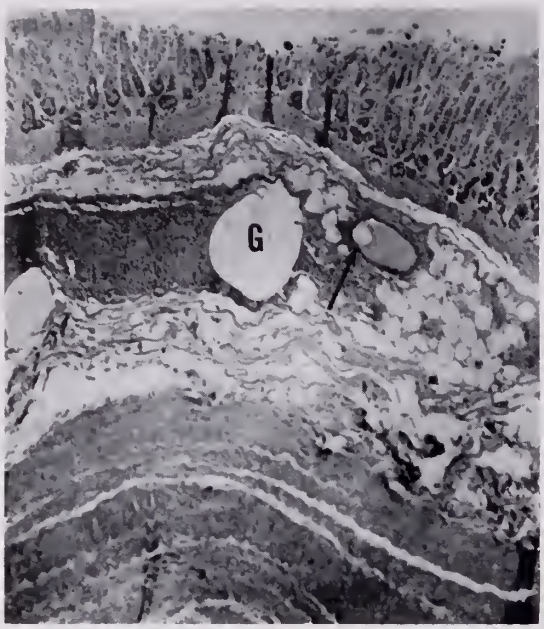

Fig. 3—Photomicrograph of stomach wall showing a pocket of gas (G) in the submucosa adjacent to a small hemorrhage. A small vein also contains a pocket of air (arrow). The mucosa shows parenchymatous degeneration. X 37

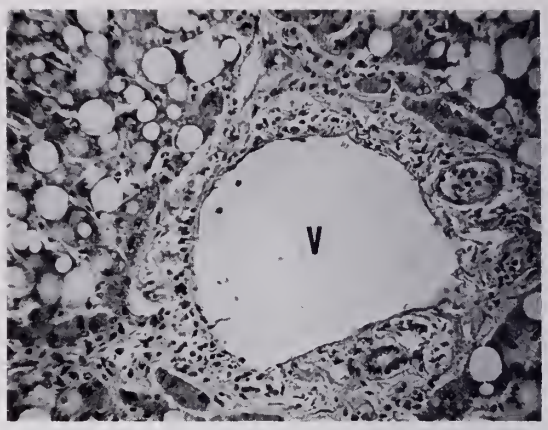

Fig. 4—Photomicrograph of liver showing portal vein (V) in portal triad markedly dilated by gas. There is a moderate fatty degeneration of the liver cells. X 150

Pathologic Findings. *Doctor Bloodworth:* There was a moderate generalized arteriosclerosis. The heart weighed 420 gm and exhibited moderate left ventricular hypertrophy, mild coronary arteriosclerosis, and focal fibrosis. The foramen ovale was functionally patent with a diameter of approximately 1 cm, which probably accounted for the cardiac murmur. The lungs showed moderate chronic passive congestion which we believe was due to the terminal shock.

The main pathology was in the abdomen. The orifice of the superior mesenteric artery was 90 to 95 per cent occluded by old, organizing and recent thrombi (Fig 2). The esophagus was not remarkable. The stomach contained 400 ml. of reddish-brown fluid; the mucosa was hemorrhagic and partially necrotic. The small intestine contained approximately 2000 ml. of reddish, foul-smelling fluid, in addition to a similar amount of air. The entire wall of the small intestine was dark reddish-purple; the serosa was dull and occasionally covered with strands of fibrin. The proximal half of the colon contained approximately 500 ml of dark red, foul-smelling fluid and the wall was similarly discolored, although not as severely as in the small intestine.

The vermiform appendix was intact. There were approximately 200 ml of dark red fluid in the abdominal cavity—all of which had collected since surgery. A large area, 6 to 8 cm in diameter, in the retroperitoneal space behind the lesser sac was soft, greenish-yellow, and crepitant. The walls of the stomach, small intestine, and proximal half of the colon were moderately crepitant.

On section, foamy yellow fluid oozed from the common bile duct. Similar foamy fluid exuded from the portal areas of the cut surface of the liver. Microscopic sections revealed gas pockets in the stomach wall, intestine, portal veins, and parenchyma of the liver (Figs 3 & 4).

The left renal artery was arteriosclerotic and the orifice was 70 per cent occluded. The possibility that this man had renal hypertension caused by partial sclerotic occlusion of one renal artery is especially suggestive due to the age of the patient. There was also an unexplained, heavy hemosiderosis of the spleen and bone marrow.

The terminal blood urea nitrogen was 23 mg/100 ml. Cultures of the lesser peritoneal sac and liver exudate revealed the same organisms found in the peritoneal fluid during life; that is, Streptococcus faecalis, Klebsiella aerobacter, and Clostridium welchii.

Final Diagnoses: 1. *Hypertensive-Arteriosclerotic-Cardiovascular-Renal Disease with:* (a) Left ventricular myocardial hypertrophy; (b) arteriosclerosis of cerebral arteries, mild; (c) arteriosclerosis of aorta, moderate; (d) arteriosclerosis of coronary arteries with approximately 50 per cent occlusion of

all branches; (e) arteriosclerosis of left renal artery with 70 per cent occlusion; (f) arteriosclerosis and thrombosis of orifice of superior mesenteric artery with 90 per cent occlusion.

2. *Ischemic and Bacterial Gangrene of Part of Stomach, Entire Small Intestine, and Right Half of the Colon.* 3. Patent foramen ovale with systolic murmur. 4. Ascending cholangitis and hepatitis due to Clostridium welchii. 5. Retroperitoneal abscess behind lesser sac due to Clostridium welchii. 6. Hemosiderosis of spleen and bone marrow, unexplained. 7. Hyperglycemia, possibly due to diabetes mellitus.

In our opinion, the sequence of events is best explained as follows: This patient had hypertension and severe arteriosclerosis of the orifice of the superior mesenteric artery. His blood pressure dropped for unknown reasons, as is not uncommon in patients with such high initial pressure. Because of the small size of the orifice of the superior mesenteric artery, there was a resulting ischemia of the small intestine and portions of the colon with gangrene. The gas bacillus present in the intestinal lumen, as is quite frequent, then gained entrance into the wall of the intestine, causing clostridium gangrene of the intestine to be superimposed on the ischemic gangrene already present. Subsequently, the infection spread to the biliary tree and portal blood system.

It should be pointed out that the association of massive gangrene of the intestine which may, at times, include the esophagus, stomach, small intestine and colon, may be due to an enteric organism, especially Clostridium, which gains entry during episodes of lowered resistance of the intestine from any cause, and may then spread to cause massive gangrene. Thus, massive clostridial infection must be included in the differential diagnosis of massive intestinal gangrene.

I first became aware of this condition from a series of papers presented as a symposium in the Feb. 12, 1949, issue of the *British Medical Journal.*[3-6] Many confirmatory papers have appeared since, but this symposium remains an excellent reference to this condition. Several authors point out in this symposium that the condition is usually due to Clostridium welchii, type F. A detailed description of this type of bacillus is obtained from this symposium. It is quite heat resistant and one way to identify this organism is to heat the culture for one hour at 100 C. Other types of Clostridium welchii and, in fact, most organisms, will be killed by this procedure, but not type F. This organism is sensitive to penicillin in in-vitro tests at a concentration of 10 units, but not one unit of penicillin per milliliter.

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TREATMENT OF URINARY TRACT INFECTIONS IN CHILDREN *continued from page 293*

ACKNOWLEDGMENT: I am indebted to my clinical colleagues for their opinions and advice.

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* * *

EXPORT SALES of drugs reached a record of $290 million in 1964, up 7.8 percent from 1963, according to a report from the U. S. Department of Commerce. Drug imports dropped 14.6 percent to $41 million.

THE PRESIDENT'S PAGE . . .

J. H. HOUGHTON, M.D.
Wisconsin Dells

DOCTORS—YOUNG AND OLD!

Organized Medicine Needs Your Interest

■ BEING A DOCTOR of medicine nowadays means more than merely taking care of the health needs of people. So many changes are taking place in our socio-economic ways of life that it behooves all of us, no matter what our special interests within the profession, to be informed of and alert to the changes that may affect us, and those with whom we deal. Different philosophies may take the popular fancy. We are currently changing or perhaps have already changed from the philosophy that every individual is responsible for his own welfare into one that will have us believe that the government, or at least some outside agency, under certain circumstances, is responsible for our health needs.

The practice of medicine, as we have known it, which has served public health well, is in grave danger of being replaced with a different and untested concept. In addition, there are many ancillary or paramedical groups who are trying to legislate themselves into activities and privileges for which they do not have the proper training. These groups spend money and time in furthering their efforts, not by education but by influencing legislators. To safeguard the public health, their efforts must be exposed and defeated.

My plea today is for the young man in our profession to become actively interested in and informed about the current trends and in some manner influence their direction. Perhaps we need more young thinking in organized medicine. Perhaps a combination of young and old thinking will be the answer.

In any event, may I plead that all doctors, young and old, interest themselves in this other side of medicine. Take an active part in your County Medical Society and through it, in your State Medical Society and the A.M.A. If you are interested and wish to help, talk to your Councilor and he will direct you properly. Medicine needs more assistance from its own members. Won't you please aid in preserving the best quality of medical care the world has ever known? If you are not currently active,—jump in! The water's fine.

J. H. Houghton, M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Carl N. Neupert, M.D.

■ WHEN DR. CARL N. NEUPERT retired last May as state health officer, he received due acknowledgment of the fine job he had done since 1943. The Wisconsin Senate passed a resolution expressing official gratitude for his career in the health service of Wisconsin, and the State Medical Society bestowed the Council Award, its highest honor, in recognition of his distinguished achievement.

Doctor Neupert has long been a warmly regarded figure in Wisconsin medical circles. For years his short, succinct, fact-filled report on public health activities in the state was a welcomed feature of the annual meeting of the House of Delegates. His gentle, congenial personality is a delight to those who have the pleasure of professional and social contact with him.

The honors that Doctor Neupert received on his retirement as health officer, however, are paled into insignificance beside the real magnitude of his accomplishments. Presiding over a large staff of physicians, sanitary engineers, nurses and public health administrators, Doctor Neupert brought about many improvements in state-wide public health. Under his aegis, trained public health nurses were employed in every county in the state. As a result of a far reaching and consistent educational program, infant mortality rates were drastically reduced. Improvements were made in the standards of state nursing homes, maternity wards and general hospitals. Doctor Neupert was also instrumental in extension of fluoridation of public water supplies in Wisconsin.

The better health of thousands of children, the physical well-being of hundreds of thousands of Wisconsin citizens is the true tribute to Doctor Neupert's service. Although he can be proud of the Senate's resolution and the State Medical Society's award, Doctor Neupert must surely realize that it is the better health of a community less ridden with disease that is the real reward of his work. His is the satisfaction of knowing that most of the people of his state—who may not know his name or even the nature of his job—are living longer with less susceptibility to illness because of what he has done.

No man can ask more; Doctor Neupert should receive no less. —D.N.G.

Views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

LETTERS

GUNS AND THEIR CONTROL

To THE EDITOR:

While a medical journal is an anomalous place to find an editorial about firearms, presumably the editor of any publication has the privilege of saying what he pleases on any subject. But when he does, he owes his readers the duty of being reasonably well informed about his topic. This Editor Goldstein has failed to do in his editorial in the April issue of the JOURNAL and I request equal space to refute his erroneous statements and specious arguments.

Like thousands of other citizens he has fallen victim to the vicious and vociferous propaganda of the anti-gun crowd whose thesis is, "Guns cause crime and therefore should be prohibited (or controlled, regulated, registered, or whatever)". Even a moment's thought will convince any reasonable person that no gun ever caused any crime by itself. True, guns are used by criminals, but they do not cause crime. Guns are also used by law-abiding citizens to protect themselves and their property from *armed* criminals. Guns, both large *and* small, are used by our government to protect the nation as a whole from international criminals who are armed. Would Dr. Goldstein have the United States throw away its arms just because other nations are misusing theirs?

Dr. Goldstein urges reading the *entire* Second Amendment to the Bill of Rights in order to understand its meaning. Obviously he did not follow his own advice. He says, "Although the Amendment referred to the right to bear arms *as members of a militia*, as a reading of the entire Amendment makes clear, - - - etc." It says no such thing! Here *is* the entire Amendment. "A well regulated militia, being necessary to the security of a free state, the right *of the people* to keep and bear arms shall not be infringed." (Underscoring mine.) I submit that *we*, you and I, are "the people" and unless *we* can keep and bear arms there can be no militia and hence no freedom or security in our state. What Dr. Goldstein proposes would change all this—and not to our advantage—but to that of criminals who would never register *their* arms or voluntarily surrender them. I firmly believe that anything which restricts or prevents access to, or ownership of, firearms by law-abiding citizens is not in the public interest and is a threat to our national security. A disarmed general public would be easy prey for a determined and well armed group of men. While the murder of a president by a demented assassin is a great tragedy, this is a hazard inherent in the office of Chief of State and should not be an excuse for disarming our citizens. We can, and do, replace a president easily, but we can never replace our constitutional government easily. That I am not alone in this idea, I offer the following quotation:

> "By calling attention to 'a well regulated militia,' the 'security' of the nation, and the right of each citizen 'to keep and bear arms,' our founding fathers recognized the essentially civilian nature of our economy. Although it is extremely unlikely that the fears of governmental tyranny which gave rise to the Second Amendment will ever be a major danger to our nation, the Amendment still remains an important declaration of our basic civilian–military relationships, in which every citizen must be ready to participate in the defense of his country. For that reason I believe the Second Amendment will always be important."

Who said that? John Fitzgerald Kennedy!

Finally, there is no proof that the regulation, restriction, or registration of firearms will have any material influence on the reduction of the crime rate in this country. Certainly the Sullivan Law in New York has not reduced New York's crime rate which is nearly as high as any other state in the Union. Furthermore, there is considerable evidence to show that the accessibility of firearms has very little to do with the murder rate in this country. A recent F.B.I. report shows that since 1930 the murder rate in the United States has declined 40%. In the same period the number of civilian owned firearms in the United States has increased enormously and since the end of the last war the interest in shooting as a healthful recreation has increased tremendously. There can be no doubt that firearms are used by criminals, but corrective measures should be directed against the criminals and not against firearms. Congressman Bob Casey of Texas has the right idea when he proposes very severe penalties for using a firearm during the commission of a felony. To support this stand, I submit the following quotation from Police Superintendent Robert V. Murray, Washington, D. C.:

> "It may be argued that any legislation that would reduce the number of pistols in circulation would substantially reduce the number of aggravated assaults. The argument rests on two mistaken premises. First, it assumes that restrictive legislation will prevent criminals from obtaining guns. The fact is that experience has shown that legislation such as the New York Sullivan Law does not reduce the number of pistols in the hands of criminals. Second, the argument assumes that guns are used in most aggravated assaults, whereas the fact is that they are used in only a small percentage of such assaults."

If these are the facts, then why is the anti-gun crowd so anxious to disarm the civilian population of this land of freedom? I leave the answer to that question to the reader!

H. M. AITKEN, M.D.
Eau Claire, Wis.

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to:* THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin, 53701.

the wisconsin medical journal

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REPORTS AND PROCEEDINGS OF MAY 1965 SESSION

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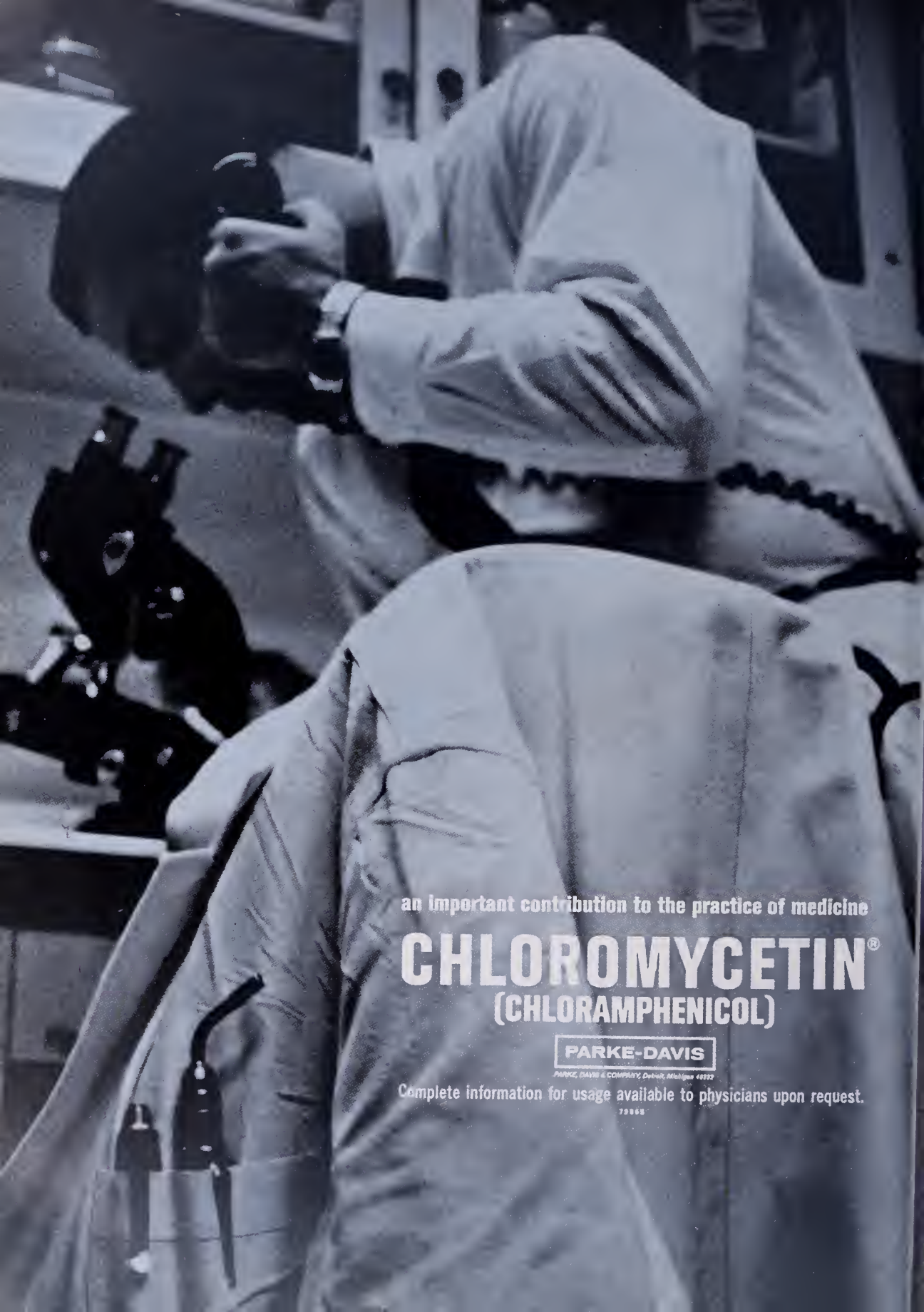
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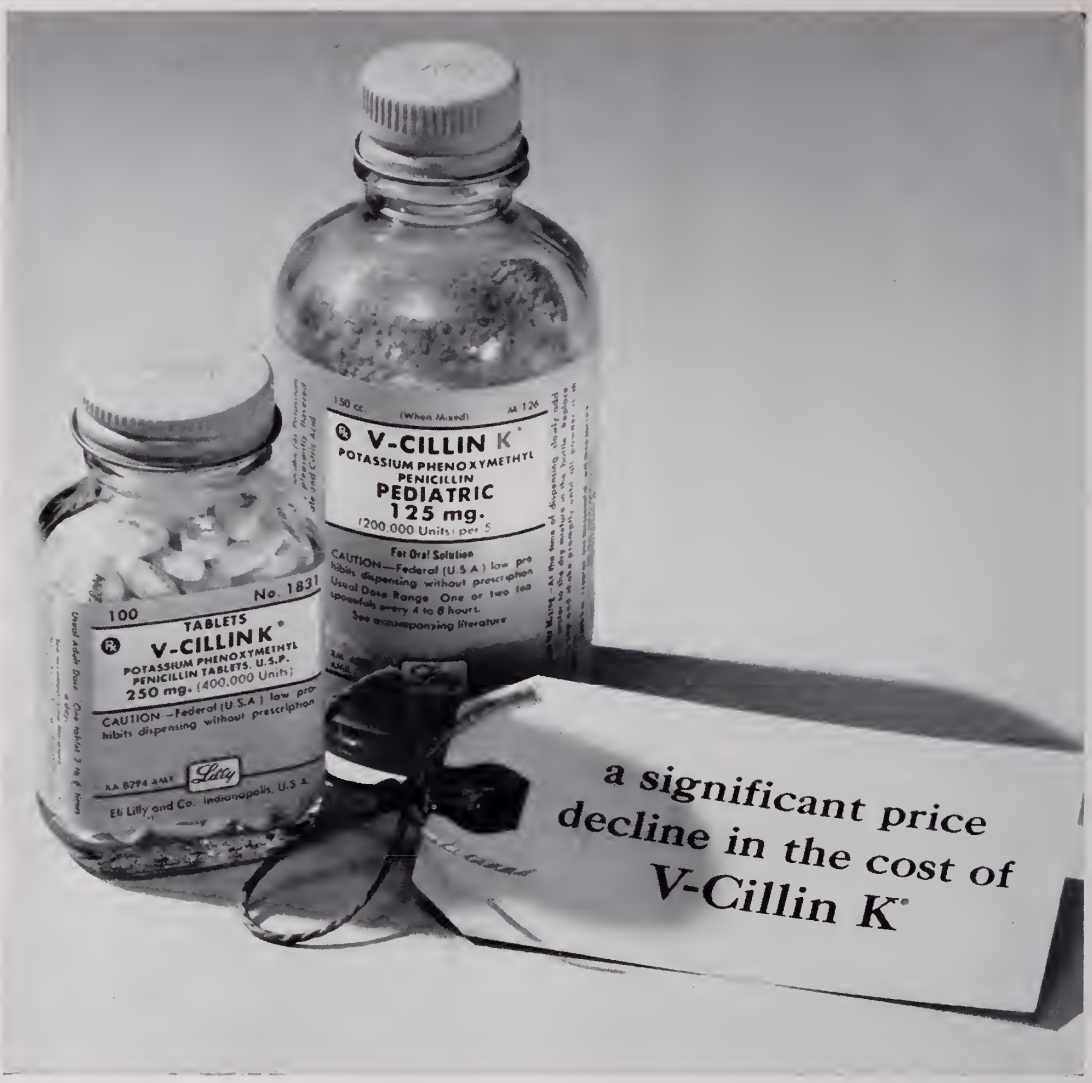

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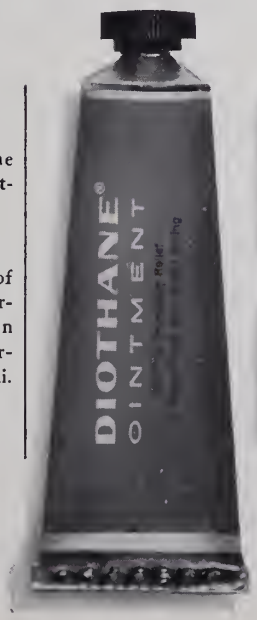

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COUNTY SOCIETY PROCEEDINGS

CLARK

Three Clark County attorneys accepted the invitation of the Clark County Medical Society to attend its meeting on July 8 in Loyal. A representative of the State Medical Society explained the differences in legislative approaches between Washington, D.C., and Madison, and gave other information of a similar nature. A dozen county physicians attended.

DANE

Although no regular meetings were held by the Dane County Medical Society in July and August, the board of trustees met as usual.

New members of the society are *Drs. Charles L Jahn* and *Charles E. Yale*. A Milwaukee native, Doctor Jahn graduated in 1961 from the University of Wisconsin Medical School, interned at Children's Orthopedic Hospital at Seattle, Wash., and completed resident training in pediatrics at University Hospitals. He is now in private practice in Madison. Doctor Yale was born at Aurora, Ill., and attended Western Reserve University where he received his medical degree in 1955. He served his internship at Cincinnati General Hospital in Cincinnati, O., and completed resident training in surgery at the University of Cincinnati. He is an assistant professor of surgery at the University of Wisconsin Medical School.

PIERCE–ST. CROIX

The practice of medicine and government have both changed markedly in the past 60 years, Dr. Walter Judd observed as speaker for the July meeting of the Pierce–St. Croix County Medical Society.

Addressing 50 physicians of the area, the former Congressman from Minnesota pointed out that great changes in medical knowledge have improved diagnostic ability, and research has provided doctors with drugs for the rational treatment of disease.

"Government has also changed markedly," Doctor Judd continued. The U.S. Government today, he said, is much more "for the people" and much less "of and by the people" than it was in the early days of the republic. A government "for" the people doesn't stay that way long, he commented, when it is not also "of and by" the people.

Physicians whose names appear in italics are members of the State Medical Society.

RICHLAND

"Medical and Surgical Education" was the subject of *Dr. Robert C. Hickey* as speaker for the August 5 meeting of the Richland County Medical Society, held at *Dr. R. E. Housner's* cottage near Muscoda. Doctor Hickey is professor and chairman of the Department of Surgery, University Hospitals, Madison.

TREMPEALEAU–JACKSON–BUFFALO

Members of the Trempealeau–Jackson–Buffalo County Medical Society and their wives heard a speaker from the Skemp Clinic, La Crosse, at their July 27 dinner meeting at the Midway.

* * *

CADAVER PROCUREMENT

A recent survey of the problem of cadaver procurement shows that the need is becoming greater in some areas and less in others. Over all, the situation remains essentially unchanged from two years ago, though the practice of bequeathing bodies is apparently gaining some headway.

Current information in this field is summarized in tabular form in the recently published second edition of "A Manual of Simple Burial." Also contained in the Manual is a summary, probably the most comprehensive yet published, of the problems, procedures and practices involved in the bequeathing of bodies to education and research.

The booklet also contains extensive information and directories concerning memorial societies. Eye-Banks and temporal bone banks, as well as other practical information on problems relating to death. A useful reference work for any physician.

The Manual was edited entirely without pay, and all proceeds are devoted to education. It may be ordered for $1 postpaid from Celo Press, Burnsville, North Carolina.

PAMPHLET: OVERWEIGHT—A PROBLEM FOR MILLIONS

Overweight—A Problem for Millions, a new Public Affairs Pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. In this pamphlet Michael H. K. Irwin, M.D., M.P.H., medical officer at the United Nations, discusses some of the serious diseases associated with or aggravated by obesity and suggests some of the reasons for the high incidence of overweight among people in the United States. He outlines four simple principles for dieting, pays special attention to the problem of overweight children, and answers questions about the effectiveness of exercise, drugs, and psychotherapy in helping people lose weight.

Milwaukee County Medical Assistants

Milwaukee County Medical Assistants Society officers for the year 1965–66 were installed at the annual June banquet held June 17 at the Kaiser–Knickerbocker Hotel, Milwaukee.

They are: president, Miss Judith Kerl, employed by *Dr. George Meloy;* president-elect, Miss Bonnie Zweck *(Drs. Sidney P. Hurwitz* and *Charles L. Weisenthal);* treasurer, Miss Diane Black *(Drs. Robert W. Mann* and *Edward C. Saltzstein);* recording secretary, Miss Ruth Ihde *(Dr. Mischa Lustok),* and corresponding secretary, Miss Marianne Schlederer *(Drs. Silas M. Evans* and *Robert A. Kebbekus).* The officers were installed by Miss Viola Wendt, Glendale Clinic, who is a past president, as well as a past president of the Wisconsin State Medical Assistants Society.

Featured speaker of the evening was Brookfield physician, *Dr. Robert S. Pavlie,* whose talk was entitled "ESP—Mind or Matter." The evening wound up with a dance demonstration by members of a local dance studio.

PROCEEDS OF MILWAUKEE County Medical Assistants Society's annual charitable function were used to purchase a Padgett Dermatome with drum, head, and adapter, and a Teletherm constant reading thermometer for presentation to the St. Mary's Hospital Burn Center, Milwaukee. Sister Dorothea, supervisor of pediatrics and the pediatric section of the Burn Center, and *Dr. George E. Callentine, Jr.,* its clinical director, are shown accepting the equipment. MCMA members pictured with them are, left to right, Miss Marvis Sitkaski (employed by *Dr. James J. Barrack),* president; Miss Lucille Kumenius, *(Dr. Thomas Calvy),* and Miss Bernadine Baulia *(Dr. Paul F. Hausmann),* public relations.

Douglas County Medical Assistants

The Douglas County Medical Assistants Society was featured in a full-page pictorial story in the June 26 edition of the SUPERIOR EVENING TELEGRAM. Pictures included views of the group's officers, who were elected in June. They are: Mrs. Louise Cohn, president; Mrs. Russel Johnson, president-elect; Mrs. Emma Larson, secretary; and Mrs. Alfred Dietrich, treasurer. Mrs. Marion Baker is the outgoing president.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Mid-America Society of PM&R

Dr. Paul A. Dudenhoefer, Milwaukee, who was recently named president of the Mid-America Society of Physical Medicine and Rehabilitation, asks all Wisconsin physicians who either practice physical medicine and rehabilitation, or are interested in this area of medical practice, to apply for membership in the society, which replaces the Chicago Society of Physical Medicine and Rehabilitation. All inquiries should be directed to *Edwin C. Welsh,* M.D., St. Luke's Hospital, 29th and Oklahoma Ave., Milwaukee, Wis.

Doctor Welsh is temporary chairman of the Wisconsin–Illinois Divisions and *Dr. Frank Balistreri,* Milwaukee, is serving as temporary secretary–treasurer of the local division.

* * *

ALCOHOLISM SLOGAN CONTEST

As a way of helping to arouse the public to the need for action in overcoming the disease of alcoholism, the Christopher D. Smithers Foundation in New York is sponsoring a slogan contest for the National Council on Alcoholism, only national voluntary health agency in the field.

Prizes will be presented during Alcoholism Information Week, November 28–December 4, in New York City. First prize will be $1,000, second $500, and third, $250, with expense paid trips to New York for the prize presentations. Seven additional prizes of $100 each will be given.

The slogan, which must be ten words or less, should do two things: 1) arouse public concern about the disease of alcoholism; and 2) contain a concrete appeal for funds. Entries must be postmarked on or before October 31.

* * *

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Dr. Smith Sailing on Mercy Cruise

Such undeveloped areas of the world as backwater South American port cities, where he will do what he can to improve the people's health, will be the destination of *Dr. Porter H. Smith*, former anesthesiologist at St. Joseph's Hospital, Milwaukee, when he sets sail from New Bedford, Mass., in October for a three year cruise in his medically-equipped 45 foot ketch, the Christiania. A graduate of Harvard and the University of Pennsylvania Medical School, Doctor Smith hopes to receive the backing of Project Hope or some similar organization, working within which he could take his sailing dispensary to waters where a larger vessel could not go. His wife and three little daughters will accompany him.

That Doctor Smith should want to combine his medical practice with sailing is only natural. His father, the late Rear Admiral Edward H. Smith, was himself the son of a Martha's Vineyard whaling captain. Doctor Smith has sailed to Greenland on coast guard ice patrol with his father and served in the Merchant Marine after World War II, skirting the coast of South America, and Turkey, Italy, Greece, and Spain.

After the hurricane season, Doctor Smith plans to sail down the east coast to the Caribbean to familiarize himself thoroughly with the ketch before setting out for more distant ports.

MILWAUKEE JOURNAL Photo

POINTING TO THE MAP, Dr. Porter H. Smith enthusiastically discusses the mercy cruise on which he is sailing this fall. Watching are his wife and three little daughters, Teresa, Jennifer and Sarah Janes, wha will accampany him an the three year voyage.

Dr. Curet Studying at Yale

Dr. Luis B. Curet, University Hospitals, Madison, left August 31 for one or two years of postgraduate work in the Department of Physiology at Yale University Medical School, New Haven, Conn.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Dr. Conrad Joins Group

Drs. L. J. Van Hecke, F. P. Falsetti, and *F. L. Ziehl* announce the association of *Dr. Arthur B. Conrad* in the Clinical Laboratory on West Center Street, Milwaukee.

Dr. Campbell AMA Section Delegate

Dr. Ralph E. Campbell, University Hospitals, Madison, has been named delegate of the American Medical Association's Scientific Assembly Section on Obstetrics and Gynecology.

MDA Furthers Dr. Angevine's Research

A check for $22,500 was presented to *Dr. D. Murray Angevine,* chairman of the Department of Pathology, University of Wisconsin Medical School, and to Drs. Ikuo Goto and Tsunoru Miyazaki during the summer on behalf of the Muscular Dystrophy Association.

Henry Q. Turville, president of the association's Madison area chapter, presented the check. He contributed $12,000 for Doctor Angevine's electron microscopy studies on regeneration of muscles in normal and diseased animals, and $10,500 for postdoctoral fellowships in neurology at Wisconsin for Doctors Goto and Miyazaki. The two are members of the University of Kyushu faculty of medicine in Fukuoka City, Japan. Since 1950, the association has given almost $270,000 in research grants to the University.

Dr. Rapkin Joins Madison Group

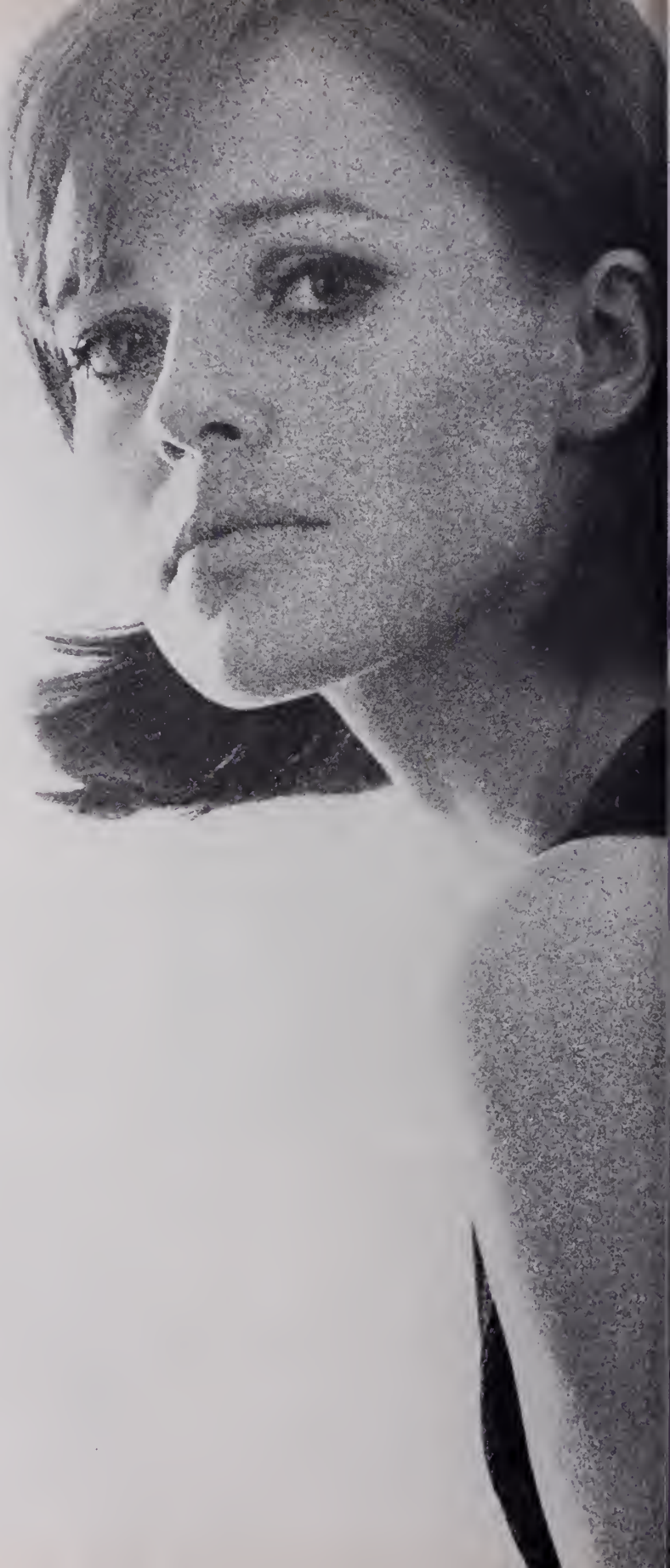
Dr. Mitchell A. Rapkin completed his residency at University Hospitals, Madison, July 31 and since August 1 has been associated with Madison Physician Anesthetists.

Dr. Gundersen Joins Clinic

Gundersen Clinic and La Crosse Lutheran Hospital, La Crosse, have announced the association of Dr. Cameron B. Gundersen in the department of pediatrics. He is the son of *Dr.* and Mrs. *Gunnar Gundersen,* La Crosse.

After receiving his M.D. degree in 1956 from Boston University Medical School, Doctor Gundersen served a year's internship at Children's Hospital, San Francisco, Calif. Following 7½ years of service at U.S. Air Force bases in the United States and Germany, he served a two-year residency at Boston

too young to be so tired...



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City Hospital, followed by a two-year National Institutes of Health fellowship at the University of Chicago, which he finished in June.

Dr. Goodsitt Honored on Retirement

In recognition of his retirement from service after 43 years with the Milwaukee Health Department, *Dr. Alfred H. Goodsitt* was honored by members of the department and guests at a dinner July 15 at Alonzo Cudworth American Legion Post, Milwaukee.

A Milwaukee native, Doctor Goodsitt received his M.D. degree from Marquette in 1921, interned at Milwaukee County Hospital, and did postgraduate work at Manhattan Eye, Ear, Nose, and Throat Hospital. He began work with the Milwaukee Health Department in 1922 as a part-time physician and during his 43 years of service has worked in behalf of thousands of children. He accepted a gift from fellow employes and received a plaque from the city of Milwaukee. Letters were read from Mayor Henry Maier and *Dr. E. R. Krumbiegel*, Milwaukee health commissioner and other statements of appreciation were made by *Dr. Virginia Downes*, superintendent of the Bureau of Maternal and Child Health, and Dr. Edward A. Heffner acting on behalf of his fellow members of the Health Department.

Drs. Johnson, Mueller Join Staff

The Sheboygan Clinic has announced the association of Drs. Rodney C. Johnson and Howard A. Mueller, Doctor Johnson on July 6 in the department of psychiatry and Doctor Mueller July 12 in the department of internal medicine.

In conjunction with his private practice, Doctor Johnson has been engaged to serve the Sheboygan Guidance Center on a one day a week basis. He received his medical degree in 1961, served his internship at James Decker Munson Hospital, Traverse City, Mich., and a residency in psychiatry at the Minnesota Medical School. In 1951 and 1952 he served in the Army and was stationed at Fort Sam Houston, Texas.

Doctor Mueller has an M.D. degree from the University of Illinois College of Medicine. He interned at Presbyterian-St. Luke's Hospital, Chicago, where he also served a three-year residency in internal medicine, and a fellowship in metabolism and endocrinology. During two years with the Air Force he acted as chief of medical services at the base hospital at Larson Air Force Base in Washington.

Drs. Waun, Lamar on UW Staff

Dr. James E. Waun has been named instructor in anesthesiology at the University of Wisconsin Medical School, Madison. He has an M.D. degree from Wayne State University, Detroit. A newly ap-

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.

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pointed assistant professor of medicine is Dr. Carlos Lamar, Jr., who holds a clinical investigatorship at the Veterans Administration Hospital.

Foundation Elects Dr. Hildebrand

Dr. William B. Hildebrand, Menasha, was elected chairman of the Medical Advisory Board of the Sears–Roebuck Foundation at its 23rd meeting June 19 in New York City. For the preceding two years, Doctor Hildebrand had been a member of the board representing the Midwest.

Dr. Vig Heads State Board

Dr. Edward N. Vig, Viroqua, was elected president of the State Board of Health at its monthly meeting in July at Madison. *Dr. Jacob Kaufman,* Green Bay, a member of the board, was named to Doctor Vig's former position as vice-president.

Named to Board of Examiners

Drs. Robert G. Zach, Monroe; *Fordyce Ross,* Wauwatosa, and *T. W. Tormey, Jr.,* Madison, were appointed by Gov. Warren P. Knowles July 2 to the State Board of Medical Examiners. Outgoing board members are *Drs. William C. Henske,* Chippewa Falls; *Richard J. Rogers,* Elkhorn, and David A. Werner, Sheboygan.

Dr. Gimenez at Berlin

Dr. Alonzo Gimenez arrived in Berlin in mid-July to open a practice in association with *Dr. David Sievers.* He came to Berlin after completing a five-year tour of duty with the U.S. Army. Holder of an M.D. degree from St. Louis University, he interned for a year and spent four years in surgical training at Milwaukee County Hospital.

Dr. Bock Retires

Dr. A. B. C. Bock retired at the end of June after practicing in Sheboygan since October 1933.

Dr. Dockendorff Appointed

Dr. Bernard C. Dockendorff, former Arcadia physician, was named chief of the outpatient service in July at the Veterans Administration Center at Wood. He joined the staff at Wood in 1959. In his new assignment, he is assuming the responsibilities of the late Dr. S. E. Sebastian.

Dr. Gutenberger Receives Fellowship

Dr. James E. Gutenberger, 1964 graduate of the University of Wisconsin Medical School, Madison, was awarded the Wyeth Laboratories fellowship in pediatrics during the summer and on July 1 began his residency at the University. He is from Sheboygan.

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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PHYSICIAN NEWS *continued*

Dr. Hudek Honored

Dr. D. F. Hudek, Bloomer, received a gift from the Bloomer Chamber of Commerce in June in commemoration of his 50 years in the medical profession.

Dr. Gallagher at Green Bay

A former resident of Green Bay, Dr. Donald John Gallagher, opened an office in that city July 19 for the practice of obstetrics and gynecology. A graduate of the University of Wisconsin Medical School, he interned at St. Mary's Hospital, Duluth, Minn., and completed training in his specialty at Milwaukee County Hospital.

Dr. Morrow Joins Dr. Sneed

Dr. Kenneth A. Morrow, ophthalmologist, joined *Dr. R. J. Sneed* July 19 as an associate in practice at the Ashland Eye Clinic. He is a native of British Columbia who received his medical degree in 1959 from the University of British Columbia Medical School. Doctor Morrow interned at Vancouver General Hospital, served a two-year preceptorship in ophthalmology at the Minot Eye, Ear, Nose and Throat Clinic, Minot, N.D., and has completed three years of residency training in ophthalmology at Henry Ford Hospital, Detroit, Mich.

Dr. Paul J. Meis at La Crosse

Dr. Paul J. Meis joined the La Crosse Clinic in July. He is associated with *Dr. Ubaldo Alvarez* in the practice of gynecology and obstetrics. Doctor Meis graduated from the University of Iowa Medical School in 1959, interned at Martin Army Hospital, Fort Benning, Ga., served two years in Germany with the Army Medical Corps and recently completed specialty training at State University of New York Medical Center at Syracuse.

Dr. Henningsen at Rice Lake

Dr. John Henningsen joined the staff of the Maser Clinic, Rice Lake, July 1 as an associate of Drs. *J. F. Maser*, *L. R. Cotts*, and L. A. Kristensen. Doctor Henningsen has an M.D. degree from the University of Nebraska Medical School. He served his internship at Sioux Valley Hospital, Sioux Falls, S.D., and for the past two years has been associated with the U.S. Public Health Service as head of the surgical department of the medical center for federal prisoners at Springfield, Mo.

Marshfield Clinic Additions

Dr. Robert P. Haight, urologist, and Dr. Andrew G. Dillard, obstetrician and gynecologist, have joined the staff of the Marshfield Clinic. Doctor Haight, a 1954 graduate of Creighton University Medical School, Omaha, Neb., was a major in the Army Medical Corps from 1956 until the end of this

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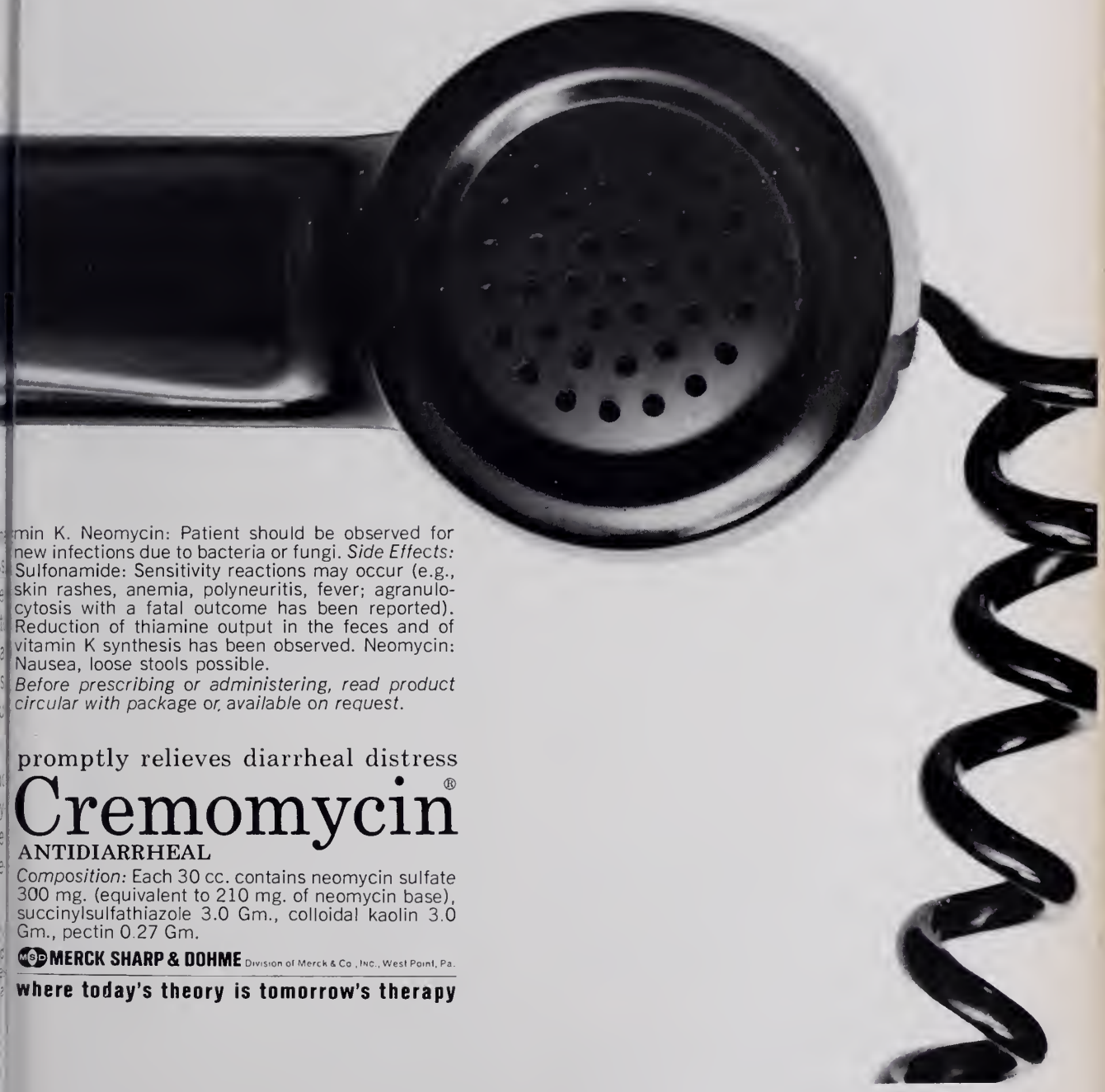

min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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past June. Doctor Dillard, who took his medical training at the University of Texas Southwestern Medical School at Dallas, has been in residence at the Indiana University Medical Center in Indianapolis. From 1951 to 1954 he served with the U.S. Air Force in Korea.

Dr. Thomas at Prentice

Dr. Griffith L. Thomas opened a private practice in Prentice in July. He received his doctor of medicine degree from Loma Linda University, Loma Linda, Calif., and for the past year has interned in Hinsdale, Ill.

Dr. Honish Opens Oconto Practice

Dr. John Honish, physician and surgeon, opened a practice in Oconto on July 12 in the offices of the late Dr. H. A. Aageson. A graduate of the University of Wisconsin Medical School, he has just completed his internship at La Crosse Luthern Hospital.

Dr. Thranow at Valders

Dr. John A. Thranow, Jr., assumed the practice of *Dr. William E. Acheson* in July at Valders. After practicing at Valders for 11 years, Doctor Acheson has moved to La Mesa, Calif. His successor at Valders has an M.D. degree received in 1963 from the University of Wisconsin Medical School, Madison. He took a year of internship and a year of surgical residency at La Crosse Lutheran Hospital and the Gundersen Clinic, La Crosse.

Dr. Rian at Green Bay

Dr. Oliver Rian, a graduate of Marquette University School of Medicine, Milwaukee, opened a practice in dermatology July 12 in Green Bay. Dr. John Marnocha is associated with him on a part-time basis in the office occupied by the late Dr. Philip Christensen.

After practicing medicine in Peoria from 1935 to 1942, Doctor Rian served in the Army Air Force Medical Corps for four years. From 1947 until 1950 he took training in dermatology at several hospitals in Illinois, and from 1950 until he transferred to Green Bay, he practiced dermatology in Peoria.

Monroe Clinic Additions

Three physicians joined the staff of the Monroe Clinic during the early part of July. They are Dr. Thomas L. Watt, department of dermatology; Dr. Benjamin M. Rush, department of surgery and proctology, and Dr. Bill L. Maddix, internal medicine.

Doctor Watt received his M.D. degree in 1960 from Harvard Medical School and interned at Mary Hitchcock Memorial Hospital, where he also served residencies in both internal medicine and dermatol-

ogy. Prior to locating in Monroe he was dermatologist at the Hitchcock Clinic, Hanover, N. H.

A native of Mississippi, Doctor Rush has an M.D. degree from Louisiana State University Medical School. He served a residency at the Ochsner Foundation, New Orleans, and from 1959 until he came to Monroe was engaged in the practice of surgery and proctology at Lake Charles, La. Earlier, from 1952–54, he was engaged in general practice in Mississippi, and in 1958 he was an instructor in surgery at Tulane University.

A 1961 graduate of the University of Kansas Medical Center, Doctor Maddix did postgraduate work at the University of Michigan. His internship was served at St. Luke's Hospital, Duluth, Minn., and his residency at Hurley Hospital, Flint, Mich.

Dr. Viel Starts Brookfield Practice

Dr. Robert S. Viel has joined *Dr. Donald Wood* in general practice in Brookfield. A graduate of Marquette University School of Medicine, he interned at St. Joseph's Hospital, Milwaukee.

Dr. Bongiorno to California

After practicing for 26½ years in Albany, *Dr. F. J. Bongiorno* closed his practice there August 21 and left for Oakland, Calif., where he planned to operate a clinic which will include his sons, Joseph and Felix, Jr., when they complete their medical studies.

Dr. Brende on World Tour

Dr. Joel Brende, general practitioner at St. Croix Falls, and his wife left August 1 for a two-month world tour, following which Doctor Brende will for two months assist as physician at a Lutheran mission in New Guinea. The Brendes have sold their home in Taylors Falls, Minn., which is just across the state line from St. Croix Falls.

Dr. Bentson to Korea

After completing a three year residency in radiology at University Hospitals, Madison, Dr. John R. Bentson reported for duty in the Army early in July at Fort Sam Houston, San Antonio, Texas. After a brief training period, he was to leave for service in Korea. Doctor Bentson, who is from rural Viroqua, received his M.D. degree from the University of Wisconsin in 1961. During his senior year he served his preceptorship in Peru, South America.

Dr. Rogne at Ettrick 40 Years

The GALESVILLE REPUBLICAN recognized *Dr. Conrad O. Rogne's* 40 years of service to the Ettrick community on July 29 with a story sketching the doctor's life eand achievements. He was honored five years ago by the community on "Dr. Rogne Day,"

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sponsored by the American Legion Post, the Republican reporter wrote, and mentioned also were Doctor Rogne's service as village health officer, chairman of the commissioners instrumental in installing water and sewage systems in the village, and as physician in charge of Red Cross Bloodmobile visits. During World War I, Doctor Rogne was a medical officer in the Navy.

Dr. Gallagher Certified

Dr. John Q. Gallagher, son of Mr. and Mrs. Lawrence J. Gallagher of Kenosha, has recently been certified as a diplomate of the American Board of Surgery. He has a private practice in surgery at Denver, Colo., where he is also a clinical instructor in surgery at the University of Colorado Medical Center. Doctor Gallagher is a graduate of Marquette School of Medicine.

Dr. Lanier Is AAUW Region Officer

Dr. Patricia F. Lanier, who with her husband, *Dr. Andrew Lanier*, operates a medical clinic at Kewaunee, was elected vice-president of the Northeast Central region of the American Association of University Women during the summer at the association's national biennial convention in Portland, Ore. She is a member of the Green Bay branch of the AAUW and immediate past president of the Wisconsin association.

Dr. Schwaegler at Beloit

Dr. Robert R. Schwaegler, general practitioner, has joined the staff of Medical Associates, Beloit. During the two years prior to his move to Beloit, he was in the Public Health Service, serving at the Indian Hospital in Pine Ridge, S.D., and as ward surgeon at the Public Health Service Hospital in Seattle. He also practiced in Dubuque and was industrial physician for the John Deere Company for a year.

Dr. Garber to Ossec

After completing his internship at Miami Valley Hospital, Dayton, O., Dr. Richard Garber joined his brother, *Dr. Bradley G. Garber*, and *Dr. Robert N. Leasum* in the practice of medicine in Osseo.

Milwaukeean Succeeds Dr. Stovall

Wilbert L. Walter of Milwaukee, director of community services of the state AFL–CIO, was elected chairman of the Wisconsin State Board of Public Welfare in July at a meeting in Sparta. He succeeds *Dr. William D. Stovall*, Madison, member of the original board of public welfare organized in 1939 and chairman of the present board since its formation in 1949.

Dr. William H. Studley, director of Shorewood Hospital–Sanitarium, was reelected vice-chairman.

Dr. Schlagintweit Leaves Arcadia

Dr. Hugo Schlagintweit, who joined Dr. Thomas Chisholm as a partner in the Arcadia Medical Center in December 1962, left Arcadia shortly after the first of July to establish a private practice in or near Vancouver, B.C., Canada.

Crivitz Welcomes Dr. Settlage

Long without a resident physician, Crivitz made a civic celebration of the opening of its new medical center the last weekend in June, when some 350 Marinette County residents and other visitors attended open house at the clinic and welcomed *Dr. Henry Settlage* and his wife, a registered nurse, to the community. Former Waukesha residents, the Settlages had vacationed in the Crivitz area for several years prior to the community's invitation to Doctor Settlage to locate there.

Dr. Wadina at Kenosha

Dr. Harold A. Bjork and *Gene F. Armstrong* of Kenosha have announced the association of Dr. Gilbert S. Wadina in the practice of radiology at Doctors Park, St. Catherine's Hospital, and Burlington Memorial Hospital.

PR Doctor Honors Dr. Tenney

Dr. H. Kent Tenney, Jr., Madison, nationally known pediatrician and emeritus clinical professor of pediatrics at the University of Wisconsin Medical School, was honored in the July–August issue of PR DOCTOR, published by the American Medical Association, for his work in health education for the State Medical Society. The honor was accorded primarily for Doctor Tenney's activities as medical director of the "March of Medicine" radio program, broadcast weekly over 51 Wisconsin stations.

"It is on this radio program," the writer of the article stated, "that Doctor Tenney puts one of his pet theories into practice. 'If you can't say something medical in words that any layman can understand, then I don't think you really understand it yourself.'

"This attitude in action, combined with his warmth, sincerity and informality, has made Doctor Tenney a favorite spokesman for Wisconsin medicine for years."

The same issue of the magazine also contains an article on the Museum of Medical Progress and Stovall Hall of Health, Prairie du Chien.

AMA Appointment for Dr. Simenstad

The Board of Trustees of the American Medical Association, meeting in New York June 18–24, appointed *Dr. L. O. Simenstad* of Osceola to fill the unexpired term of Dr. James Z. Appel, the new AMA president, as an AMA representative on the Joint Commission on Accreditation of Hospitals.

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Join Jackson Staff

Dr. David Bryant has joined the staff of the Jackson Clinic, Madison, in the department of orthopedic surgery. A graduate of New York Medical College, Doctor Bryant interned for a year at St. Luke's Hospital, Cleveland, and served a three-year residency in orthopedic surgery at University Hospitals, Madison, before joining the clinic.

Another addition to the Jackson Clinic is Dr. Laszlo Kaveggia, who joined the staff after practicing for 21 years in urology. He is a graduate of Pazmany Peter University Medical School, Budapest, Hungary, and was an assistant professor from 1951 to 1956 at the Illyes Clinic, Budapest. He came to the United States after the Hungarian Revolution, and served a four-year residency in urology at University Hospitals, Madison. He has been an instructor at Northwestern University Medical School and will continue teaching there one day a week.

His wife, Dr. Elizabeth Kaveggia, is pediatrician and assistant director of Central Wisconsin Colony.

Dovid Bryant, M.D.

Loszlo Koveggia, M.D.

Blake Waterhouse, M.D.

A third addition to the Jackson Clinic, in the department of internal medicine, is Dr. Blake E. Waterhouse, a graduate of Indiana University School of Medicine who served his internship at Iowa Methodist Hospital, Des Moines. Prior to locating in Madison Doctor Waterhouse served a three-year fellowship in medicine at the Mayo Foundation.

New at Sacred Heart Sanitarium

Dr. M. M. de Oliveira has become associated with Sacred Heart Sanitarium, Milwaukee, for both inpatient and outpatient neurological services, according to an announcement by Dr. Preston W. Thomas, medical director.

Dr. Odell Named

Dr. James E. Odell, former resident pathologist at the University of Oregon Medical School in Portland, was named in July as pathologist in charge of all laboratories at the Marshfield Clinic. A 1947 graduate of the University of Iowa Medical School, he interned at Denver General Hospital, Denver, Colo., and was a resident in pediatrics at the University of Iowa before entering the University of Oregon Medical School as a resident in pathology.

He was an associate professor in pediatrics and an assistant professor in pathology there.

Dr. Pecarski at Dousman

Dousman citizens have achieved their objective, a doctor of their own. On July 28, Dr. Miodrag B. Pecarski arrived in Wisconsin from Belgrade, Yugoslavia, climaxing negotiations which included passage of a special law waiving the state's 12 months internship requirement for physicians.

Before going to Dousman to establish his practice, the Yugoslav physician was reunited with his wife and daughter in Kenosha, where they had been staying for the past 11 months with Ald. and Mrs. Richard Froemming, neighbors of Mrs. Pecarski's father and stepmother. It was to visit the latter that the Pecarskis made their first trip to Kenosha last year.

A general surgeon in Belgrade for 12 years, Doctor Pecarski began his efforts to settle in this country at that time. He met Froemming, who learned of his desire to live in the United States, and about the same time heard also that Dousman was looking for a physician. A meeting was arranged, and following Doctor Pecarski's return to Yugoslavia (his wife and daughter remained in this country on an extended visa) Froemming and a committee of Dousman residents began working to get the doctor into the United States. Immigration officials said they would permit him to enter the country if he could start practice immediately. The way was cleared after the special law waiving internship requirements was passed, and on June 21 signed by the governor.

Dr. George Rowe Paper Published

The current August issue of CIRCULATION, official journal of the American Heart Association, publishes an article by *Dr. George G. Rowe* of Madison. The article reports research on coronary blood flow and oxidative metabolism of the muscular tissue of the heart at rest and during exercise in subjects with severe aortic valve disease.

Doctor Rowe conducted the research at University Hospitals, Madison, with the aid of a grant from the Wisconsin Heart Association. Co-authors of the article with Doctor Rowe are Doctors Skoda Afonso, Jorge E. Lugo, Cesar A. Castillo, William C. Boake, and *Charles W. Crumpton.*

OBITUARIES

Dr. Ralph G. Bonfiglio, 42, died unexpectedly May 11, 1965, in Menasha. He had practiced internal medicine in Neenah–Menasha for the past 11 years, and was on the staff of Theda Clark Hospital.

Among his survivors are his widow, Therese, and nine children, Mary Therese, Paula, Susan, Christine, Juliann, Lisa, Daniel, David, and Andrew, all at home.

A native of Sturgis, Mich., Doctor Bonfiglio was a 1950 graduate of the University of Michigan Medical School at Ann Arbor, where he also served his internship and residency at University Hospital. He was a veteran of Naval service in World War II.

Doctor Bonfiglio was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and a member of the Wisconsin State Society of Internal Medicine, the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He established the specialty of internal medicine in Neenah–Menasha. Prior to his arrival, there had been no internist practicing in this area from Oshkosh to Green Bay.

Dr. Stephen E. Sebastian, 69, chief medical director of the Veterans Administration regional office in Milwaukee, died May 23 at his Milwaukee home. Survivors include his widow, Marie, and four sons, John, Robert, Thomas, and David, all of Milwaukee.

Doctor Sebastian's governmental service began early in 1945 when he was appointed by the United States Civil Service Commission to the post of chief medical officer for the Seventh Civil Service Region, with headquarters at Chicago. Prior to that time he had practiced general medicine and psychiatry in Milwaukee. In 1946 he was appointed assistant chief medical director of the Veterans Administration regional office in Milwaukee, and in 1954 he was promoted to chief medical director.

A 1923 graduate of Marquette University School of Medicine, Doctor Sebastian served his internship at Milwaukee County General Hospital. He served in the Army in World War I.

Dr. Henry O. McMahon, pediatrician since 1919 at St. Mary's Hospital, Milwaukee, and clinical professor, emeritus, and head of the department of pediatrics at Marquette University School of Medicine, died May 31, 1965, in Milwaukee at the age of 88.

Doctor McMahon, whose home was in Brown Deer, was born in New Brighton, Pa., and received his medical education at Detroit Homeopathic School of Medicine, Detroit, Mich., where he graduated in 1902. After a two-year internship spent at Grace Hospital, Detroit, he practiced in that city from 1904 to 1917 when he entered service in World War I. He was a detachment commander of the base hospital at Camp Custer, Mich., and was a captain when he left the service in 1919.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and its 50 Year Club, the American Medical Association, the Milwaukee Pediatric Society, and the American Academy of Pediatrics. He was named chairman of the Medical Milk Commission of the Milwaukee Academy of Medicine in 1931. In 1957 he was elected to honorary membership in the Milwaukee County and State Medical Societies. He had also served in past years as a member of the SMS House of Delegates and the Wisconsin State Board of Medical Examiners.

In 46 years of practice, Doctor McMahon had served on the staffs of Milwaukee County General and Milwaukee Children's Hospitals in addition to St. Mary's.

Survivors include his widow, Juliet, and a daughter, Mrs. Otto K. Namtvedt, Milwaukee.

Dr. William H. Brown, Wauwatosa general practitioner, died June 9, 1965, at the age of 89. He was a 1903 graduate of the Milwaukee Medical College, now Marquette University School of Medicine, Milwaukee.

Dr. Richard W. McCracken, 93, family physician to more than three generations of Union Grove families, died June 27, 1965, at the Racine County Hospital. Two sons, Robert McCracken of Union Grove and John McCracken of Detroit, Mich., are among his survivors.

Born in 1872 in Davies County, Indiana, he received his medical degree in 1893 after completing a three-year course in the Kentucky School of Medicine in Louisville. After practicing briefly in Montgomery, Ind., he moved in October of 1894 to Lyons, Walworth County, to take over the practice of a boyhood friend who wanted to return to the Hoosier state. About a year and a half later, in 1896, he entered into partnership with Dr. Joseph Sanders at Union Grove.

In February 1904 Doctor McCracken bought the practice and home of Doctor Lester and moved into the house in which he had ever since resided, and where he had his office. He could recall a meeting in his home during which the Racine County Medical Society was organized. He served at one time as its president and he was also a member of the State Medical Society of Wisconsin, which he had served as a delegate, and of the American Medical Association and the American Association of Railway Surgeons. He had been an honorary member of the State Medical Society since 1947 and a member of the 50 Year Club since 1948. He was also an honorary life member of the St. Mary's Hospital staff in Racine. In addition, he was very active in several civic and fraternal organizations.

In December 1946 Doctor McCracken was honored by the Racine County Medical Society as the oldest practicing rural physician in the county. In April 1951, Union Grove honored him at "Dr. McCracken Night," a testimonial dinner and reception commemorating his 55 years of service to the community.

Dr. Ezra H. Rogers, who had practiced internal medicine in Milwaukee since 1926, died June 30, 1965, at the age of 69.

He was a native of Hartford, where he practiced from 1922 to 1926 after winning his M.D. degree from Rush Medical College, Chicago, and interning for a year at Columbia Hospital, Milwaukee. Doctor Rogers was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving is his widow, Theckla.

Dr. Rogers T. Cooksey, 74, a native of Bowling Green, Ky., who became one of Madison's prominent surgeons, died July 1, 1965, in Madison.

Doctor Cooksey was former chief surgeon and chief of staff at Madison General Hospital, the same hospital to which he came to intern in 1915 after receiving his medical degree from Vanderbilt University, Nashville, Tenn. In World War I Doctor Cooksey served overseas for two years as battalion surgeon with the 127th Infantry, winning the Croix de Guerre from the French government.

For several years he was in residency at the Jackson Clinic, where he was assistant to Dr. Reginald Jackson. He entered private practice in Madison in 1923.

On June 2, 1964, the surgical staff of Madison General Hospital gave a testimonial dinner for Doctor Cooksey to honor him as he began his fiftieth year with the hospital. During that long period of time, he started a surgical residency program, was instrumental in getting the hospital recognized for intern and resident training, initiated regular medical staff meetings with established programs, inaugurated the pathology and surgical conferences, and was a pioneer in developing surgical procedures and techniques at the hospital. He was also affiliated with St. Mary's Hospital.

Doctor Cooksey was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and its 50 Year Club, the American Medical Association, the Wisconsin Surgical Society, and the American College of Surgeons, and he was certified by the American Board of Surgery. In mid-June of 1965 he was awarded an honorary life membership by the Madison General Hospital Medical and Surgical Foundation, an organization which he had helped to found. In 1961 former Kentucky Gov. Bert Combs appointed him an honorary "Kentucky colonel" because he was "an honor to the state of Kentucky." Doctor Cooksey was interested in thoroughbred racing horses and owned a farm at Bowling Green.

Survivors include his widow, Florence, and a daughter, Mrs. William G. Phelan, Madison.

Dr. Fred S. Marshall, an Appleton native who had practiced orthopedic surgery in that city since 1947 and was chief of surgery at Appleton Memorial Hospital, died July 5, 1965, in Appleton. He was 52.

Doctor Marshall was a diplomate of the American Board of Orthopedic Surgery, a member of the International College of Surgeons, the Wisconsin Orthopedic Society, Chicago Orthopedic Society, American Association of Railway Surgeons, the Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He had also served as a director of the Fox Valley Sheltered Workshop.

Doctor Marshall obtained his M.D. degree from Northwestern University Medical School in 1938 and went on to serve an internship at Madison General Hospital. For 22 months he practiced at Black Earth before going on to take his residency at Shriner's Hospital for Crippled Children, Chicago. From November 1942 to April 1946 he served with the U.S. Army Medical Corps. Before opening his Appleton practice Doctor Marshall worked in orthopedic services in several southern hospitals.

His widow, Bernice, and a daughter and son, Pamela and Fred H., both at home, survive Doctor Marshall.

Dr. Francis B. McMahon, 78, retired associate professor of surgery at Marquette University School of Medicine and member of the surgical staff of Milwaukee County Hospital, died July 7, 1965, in Milwaukee. He was a brother of the late Dr. Joseph P. McMahon.

A Milwaukee surgeon, Doctor McMahon was born in Manitowoc County in 1887. He received his medical degree in 1913 from the University of Pennsylvania Medical School, Philadelphia, Pa., and from 1914 to 1917 he interned at the Mayo Clinic, Rochester, Minn. In World War I Doctor McMahon saw service in the Army Medical Corps.

He was a member of the American College of Surgeons, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Albert M. Lindner, Racine physician, surgeon, and gynecologist, died July 12, 1965, just after performing surgery at St. Mary's Hospital, Racine. A native of St. Louis, Mo., Doctor Lindner had practiced in Racine for 40 years. He was 69 at the time of his death.

He was a member of the Racine County Medical Society (in which he had held virtually every office including the presidency), the State Medical Society of Wisconsin, the American Medical Association,

the Wisconsin Society of Obstetrics and Gynecology, the American Heart Association, and the Central States Society of Industrial Medicine and Surgery.

Doctor Lindner, who held a doctor of medicine degree from Marquette University School of Medicine, served his internship at St. Joseph Hospital, Marshfield, and did postgraduate work at the University of Vienna and the University of Budapest. In 1926 he spent three months visiting clinics in Germany, France, Switzerland, and Austria, and he took numerous postgraduate courses in New York, Chicago, and at the Mayo Clinic. He was a member of the staff at both St. Mary's and St. Luke's Hospitals in Racine.

Survivors include his widow, Dorothy, and three daughters, Mrs. Thomas Laffey, Jr., Racine; Mrs. Harry Raschke, Johnstown, Pa., and Mrs. Robert Valentine, Boston, Mass.

Dr. Clarence H. Falstad, 68, Eau Claire physician and surgeon for 35 years, died July 13, 1965, at Eau Claire. He was a native of that community.

Doctor Falstad was graduated from the University of Wisconsin as a pharmacist and completed his premedical training there. He received his doctor of medicine degree at Harvard University, Boston, Mass., in 1922, served a two-year surgical internship at Boston City Hospital from 1922 to 1924; a two-year residency in obstetrics and gynecology at Boston Lying-In Hospital from 1924 to 1926; and a two-year residency at Peter Bent Brigham Hospital in Boston from 1926 to 1928. After leaving Boston he went to the University of Iowa at Ames, to establish a department of public health for the students.

In 1930 he returned to Eau Claire to practice medicine for the next three years as a member of the Midelfart Clinic. He then moved into his own offices, where he practiced until his retirement three years ago.

Doctor Falstad was a life fellow of the American Academy of Obstetrics and Gynecology, a member and past president of the Eau Claire–Dunn–Pepin County Medical Society, and a member of the State Medical Society of Wisconsin and the American Medical Association. He joined the Luther Hospital Medical staff in 1930 and served as chief of staff from 1947 to 1949. He also served as a member of the teaching staff for the Luther Hospital School of Nursing and intern and resident program.

Survivors include his widow, Rose Bergfeld; a daughter, Mrs. Donald Ian Marshall, Manila, the Philippines; and two sons, Clarence H., Jr., Appleton, and David Bergfeld, Park Ridge, Ill.

Dr. David J. Twohig, Sr., prominent Fond du Lac surgeon, died July 20, 1965, at the age of 89. He had practiced in Fond du Lac from 1904, the year he received his medical degree from the University of Illinois, until his retirement in the mid 1950s.

Born in Osceola, he was a member and past president of the Fond du Lac County Medical Society and a life member since 1949 of the State Medical Society of Wisconsin, whose 50 Year Club he entered in 1954, the same year he was honored as a member of the 50 Year Club of the American College of Surgeons, in which he was a fellow. He was a member of and had been an alternate delegate to the American Medical Association, and he had also served as a delegate from his county society to the State Medical Society.

His association in practice with his brother, Dr. H. E. Twohig, and his brother-in-law, Dr. J. P. Connell, led to the development of what is now known as the Fond du Lac Clinic. He was a former chief of staff at Fond du Lac's St. Agnes Hospital.

Survivors are his widow and four children, including Dr. David J. Twohig, Jr., Fond du Lac physician.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 30, 1965

NEW MEMBERS

Jerome C. Brooks, 5625 Washington Ave., Racine.
W. J. Clothier, Jr., 1025 E. Broadway, Waukesha.
Lynn D. Eggman, 1020 Kabel Ave., Rhinelander.
S. L. Hadden, Wild Rose Clinic, Wild Rose.
Charles L. Jahn, 2 W. Gorham St., Madison.
Michael P. Mehr, 314 Windsor Dr., Waukesha.
Thomas A. Schroeder, 3054 N. 52nd St., Milwaukee 53210.
John C. Shields, 318 Scott St., Wausau.
Thomas E. Simonsen, 4133 Marquette Dr., Racine.
Robert L. Smith, Country Club Rd., Minocqua.
Richard H. Stone, 1305 N. 18th St., Superior.
Gamber F. Tegtmeyer, Jr., 1605 Monroe St., Madison.
Charles E. Yale, 1300 University Ave., Madison.

REINSTATED

Anne L. High, 1048 E. Lexington Blvd., Milwaukee.
Harold B. Miner, 1324 W. Wisconsin Ave., Milwaukee.

CHANGES OF ADDRESS

Donald S. Ackerman, 6815 W. Capitol Dr., Milwaukee.
Paul J. Ambro, 4314—60th St., Kenosha 53140.
Ralph T. Anderson, 3600 Tower Ave., Superior.
James F. Baumgartner, P. O. Box 379, West Bend 53095.
L. E. Becher, 815 W. Linden St., Lancaster 53813.
Fred Bechmann, 833 E. Oklahoma Ave., Milwaukee 53207.
H. A. Binnie, Kenosha, to 209 Howard St., Portage 53901.
Robert L. Bolton, 10425 W. North Ave., Milwaukee 53226.
Walid Burhani, 6530 Sheridan Rd., Kenosha.
Robert E. Carlovsky, Marshfield, to 420 E. Division St., Fond du Lac.
David J. Carlson, 2320 N. Lake Dr., Milwaukee 53211.
Marvin J. Chapman, Middletown, R.I., to 7 Suzanne Dr., Portsmouth, N.H.
Calvin O. Chicks, 101 S. Main, Janesville 53545.
Donald F. Cohill, 114 River Heights, Shawano 54166.
Arthur B. Conrad, La Crosse, to 6001 W. Center St., Milwaukee.
Dorothy Conzelman, 6530 Sheridan Rd., Kenosha.
James D. Curran, Milwaukee, to 26 Queen City, Worcester City, Mass.
Einar R. Daniels, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.
William L. Deardorff, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.
E. L. Everts, West Allis, to 10310 W. St. Martins Rd., Hales Corners 53130.
G. H. Ewell, 313 Del Mar Dr., Madison 53704.
Jordan N. Fink, Skokie, Ill., to 7930 W. Potomac, Milwaukee.
Joseph A. Fleischmann, 5148 N. 29th St., Milwaukee.
John W. Foderick, Superior, to 120½ N. Bridge St., Chippewa Falls.
Calvin Gillespie, Milwaukee, to 10949 W. Forest Home, Hales Corners 53130.
Abraham G. Gotman, Milwaukee, to 23015 Kipling, Oak Park, Mich. 48237.
W. A. Gramowski, 120 N. Green Ave., Stevens Point.
J. E. Habbe, 7015 W. North Ave., Milwaukee 53213.
Joseph E. Halloin, Green Bay, to Stormy Hill on Stormy Lake, Conover 54519.
George H. Handy, Wisconsin Rapids, to 211 S. Whitney Way, Madison 53705.
Margaret E. Hatfield, Kenosha, to 515 W. Court St., Elkhorn 53121.
James A. Heck, 6530 Sheridan Rd., Kenosha 53140.
N. J. Helland, Marshfield, to 9200 N. Third St., Phoenix, Ariz. 85020.
William L. Herner, Milwaukee, to 8111 Camino Del Oro-Plaza Apts., La Jolla, Calif.
William C. Janssen, Oconomowoc, to 11541 Shorecliff Lane, Mequon 53092.
Charles L. Junkerman, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.
Eugene Kay, 2312 W. Capitol Dr., Milwaukee.
William F. Kennedy, 120 E. Wisconsin Ave., Neenah.
George J. Korkos, St. Louis, Mo., to 811 E. Wisconsin Ave., Milwaukee 53202.
Craig Larson, Wood, to 6128 W. Washington Blvd., Milwaukee.
Thomas R. Leicht, 1821 S. Webster Ave., Green Bay 54301.
Howard Levinson, Milwaukee, to 1950 Maryal Dr., Sacramento, Calif. 94101.
Frank C. Margoles, Milwaukee, to 17366 Sunset Blvd., Pacific Palisades, Calif.
Thomas J. Martens, San Francisco, Calif., to 1825 E. Garfield St., Phoenix, Ariz.
Alfred Meyers, 7505 N. Seneca Rd., Milwaukee 53213.
Sydney M. Miller, Madison, to 1887 Dowling Ct., Santa Rosa, Calif. 95404.
Nina Mueller, 2525 S. Shore Dr., Milwaukee 53207.
Frank E. Murray, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.
W. A. Nielsen, P. O. Box 379, West Bend 53095.
Thomas M. O'Connor, Milwaukee, to 1485 Notre Dame Blvd., Elm Grove.
W. J. O'Leary, Jr., Salina, Kan., to 1000 Lake Dr., South Milwaukee 53172.
John K. Olinger, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.
Nicholas L. Owen, Milwaukee, to 14660 Golf Parkway, Brookfield 53005.
Joseph W. Pavelsek, 1508 New Pinery Rd., Portage 53901.
James P. Paulissen, Milwaukee, to 109 Warwick Dr., Lutherville, Md. 21093.
John H. Randall, 1619 Westfield Ave., Green Bay 54303.
Eugene R. Rightmyer, Milwaukee, to 114 Sherman Ave., New Haven, Conn.
Anne E. Roethke, 8323 W. Oklahoma Ave., Milwaukee 53219.
H. E. Schaefer, 1036 S. Eighth St., Manitowoc 54220.
Clayton H. Schmidt, Bellevue, Neb., to 8412 Power Dr., Wurtsmith AFB, Mich. 48753.
Clemons S. Schmidt, Madison, to 2136 Gateway St., Apt. 44, Middleton.
James T. Schulz, Milwaukee, to 1912 Atwood Ave., Madison.
Elvira C. Seno, Madison, to Nurses Quarters, V. A. Center, Wood.
David J. Sievers, 270 E. Marquette St., Berlin 54923.
Robert A. Sievert, 925 Mound St., Madison.
Thomas R. Simon, Milwaukee, to 736 Irving Ave., Syracuse, N.Y.
H. A. Sincock, 3600 Tower Ave., Superior.
Harold E. Smith, Clinton, to 601 E. 22nd St., Vancouver, Wash. 98663.
Mark Evan Speckhard, P. O. Box 408, West Bend 53095.

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W. W. Stebbins, 4021 Hiawatha Dr., Madison 53711.
Bruce J. Stoehr, Wauwatosa, to 1551 Dousman St., Green Bay 54303.
Barbara W. Thompson, 9360 N. Spruce Rd., Milwaukee.
Eugene W. Till, Cudahy, to 9403 W. Bluemound Rd., Milwaukee.
John H. Van Gilder, Milwaukee, to 13005 Wrayburn Rd., Elm Grove.
Heinz Vogel, Middleton, to 2712 Marshall Ct., Madison 53705.
Kenneth G. Werts, 4545 N. Lilly Rd., Brookfield.
Eugene L. Weston, USAF Academy, Colo., to Medical Associates, Baraboo.
Robert G. Wochos, 1821 S. Webster Ave., Green Bay.
Thomas E. Zabors, Los Angeles, Calif., to 2435 N. 111th St., Milwaukee 53226.
R. G. Zach, Rt. 2, Monroe 53566.
James S. Ziolkowski, Milwaukee, to 7400 Harwood Ave., Wauwatosa 53213.

REMOVED FROM MEMBERSHIP

Edward J. Beil, Milwaukee County, transferred to Florida.
C. H. Belcher, Winnebago County, transferred to Hawaii.
Robert J. Goldberger, Milwaukee County, transferred to California.
Marvin E. Royce, Dodge County, resigned.

DEATHS

William H. Brown, non-member, June 9, 1965.
Richard W. McCracken, Racine County, June 27, 1965.
Ezra H. Rogers, Milwaukee County, June 30, 1965.
Rogers T. Cooksey, Dane County, July 1, 1965.
Fred S. Marshall, Outagamie County, July 5, 1965.
Francis B. McMahon, Milwaukee County, July 7, 1965.
Albert M. Lindner, Racine County, July 12, 1965.
Clarence H. Falstad, Eau Claire–Dunn–Pepin County, July 13, 1965.
Walter W. Crockett, Rock County, July 16, 1965.
Otto H. Foerster, Milwaukee County, July 18, 1965.
David J. Twohig, Sr., Fond du Lac County, July 20, 1965.
Wilson S. Dunn, Dane County, July 22, 1965.
Lawrence D. Quigley, Brown County, July 24, 1965.

* * *

MEDICAL STUDENTS' FINANCES are the subject of a recent survey made by the Association of American Medical Colleges. The study shows that a single student's yearly expenses amount to around $2,700, while those of a married student with children average about $5,200. Where does the money come from? Single students usually get most of their income from their families or from jobs they hold on the side. On average, married students who have no children receive 57% of their income from their spouses' earnings. Most of the rest comes from family gifts, their own earnings, and nonrefundable grants. Other findings: Approximately 40% of all medical students are married; of these, 40% have at least one child.—*Medical World News*, April 9, 1965

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

SYNOPSIS OF CARDIOLOGY

By William I. Gefter, M.D., F.A.C.P., William J. Mullen Professor of Medicine, Woman's Medical College of Pennsylvania, and Consultant in Medicine, Veterans Administration Hospital, Philadelphia, Pa.; Bernard H. Pastor, M.D., F.A.C.P., Chief, Cardiovascular Section, Veterans Administration Hospital, and Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa., and Ralph M. Myerson, M.D., F.A.C.P., Assistant Chief, Medical Service, Veterans Administration Hospital, and Clinical Professor of Medicine, Woman's Medical College of Pennsylvania, Philadelphia, Pa. C.V. Mosby Co., St .Louis, Mo. 1965. 877 pages. Price: $9.85.

A PRIMER OF CARDIAC CATHETERIZATION

By Ross C. Kory, M.D., F.A.C.P., F.C.C.P., Professor of Clinical Research, Marquette University School of Medicine, Chief, Cardiopulmonary Laboratory, Wood Veterans Administration Hospital, Milwaukee; Theofilos J. Tsagaris, M.D., Assistant Professor of Medicine, Marquette University School of Medicine, and Chief, Cardiovascular Section, Wood Veterans Administration Hospital, Milwaukee, and Rodrigo A. Bustamante, M.D., M.R.C.P. (Edin), F.A.C.C., Assistant Professor of Medicine, Marquette University School of Medicine, and Cardiologist, Wood Veterans Administration Hospital, Milwaukee. Charles C. Thomas, Springfield, Ill. 1965. 114 pages. Price: $7.50.

NEW DRUGS

Evaluated by the A.M.A. Council on Drugs. 1965 edition. American Medical Association, Chicago.

FROM AUSCULTATION TO PHONOCARDIOGRAPHY

By Aldo A. Luisada, M.D., Professor of Medicine and Professor of Cardiovascular Research, Chicago Medical School, and Attending in Medicine and Director of Division of Cardiology, Mount Sinai Hospital of Chicago, with the collaboration of D. M. MacCanon, Ph.D.; L. M. Rosa, M.D.; P. M. Shah, M.D., and R. Zalter, M.D. C V. Mosby Co., St. Louis, Mo. 1965. 351 pages. Price: $17.75.

SURGERY OF THE PAROTID GLAND

By Robin Anderson, M.D., F.A.C.S., Head, Department of Plastic Surgery, Cleveland Clinic Foundation, Cleveland, O., and Louis T. Byars, M.D., F.A.C.S., Associate Professor of Clinical Surgery, Department of Plastic Surgery, Washington University School of Medicine, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo. 1965. 177 pages. Price: $12.75.

PHYSIOLOGIC FOUNDATIONS FOR MARRIAGE COUNSELING

By Joseph B. Trainer, M.D., Associate Professor of Physiology and Medicine, Director of Health Services, University of Oregon Medical School, Portland, Ore. C. V. Mosby Co., St. Louis, Mo. 1965. 287 pages. Price: $8.00.

TEXTBOOK OF OBSTETRICS

By John C. Ullery, M.D., Chairman and Professor of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, O.; Zeph J. R. Hollenbeck, M.D., Professor of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, O., with foreword by Richard L. Meiling, M.D., Dean, Ohio State University College of Medicine, Columbus, O. C. V. Mosby Co., St. Louis, Mo. 1965. 752 pages. Price: $17.50.

TEXTBOOK OF PULMONARY DISEASES

Edited by Gerald L. Baum, M.D., Associate Professor of Medicine, College of Medicine, University of Cincinnati, and Chief, Pulmonary Disease Section, Veterans Administration Hospital, Cincinnati, O., with 18 contributing authors. Foreword by William B. Tucker, M.D., Director, Medical Service, Veterans Administration, Central Office, Washington, D.C. Little, Brown and Company, Boston, Mass. 1965. 737 pages. Price: $27.50.

A HISTORY OF PATHOLOGY

By Esmond R. Long, Ph.D., M.D., Emeritus Professor of Pathology, Henry Phipps Institute, University of Pennsylvania, formerly Professor of Pathology, University of Chicago. Dover Publications, Inc., New York, N.Y. 10014. 1965. 199 pages. Price: $2.00.

SURGERY IN WORLD WAR II

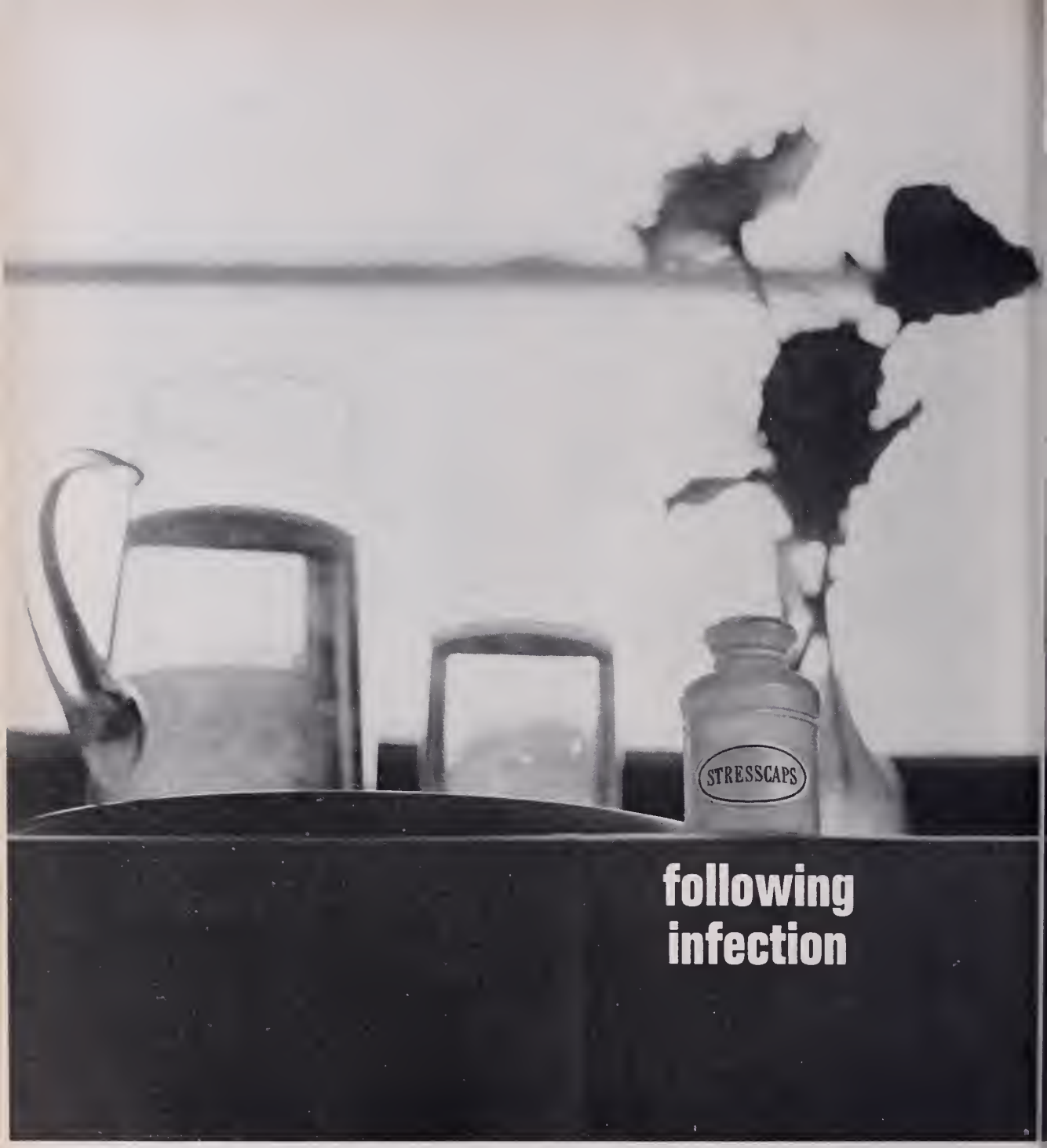
Thoracic Surgery, Volume II. Prepared and Published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor in Chief, Col. Arnold Lorentz Ahnfeldt, MC, USA; Editor for Thoracic Surgery, Frank B. Berry, M.D.; Associate Editor, Elizabeth M. McFetridge, M.A. Office of the Surgeon General, Department of the Army, Washington, D.C. 1965. 615 pages. Price: $7.25.

APPLIED HYPNOSIS AND POSITIVE SUGGESTION

In Medicine, Dentistry, and Patient Care. By George A. Ulett, M.D., Ph.D., Professor and Chairman, Department of Psychiatry at the Missouri Institute of Psychiatry (St. Louis), University of Missouri School of Medicine; Director, Division of Mental Diseases for the State of Missouri, and Donald B. Peterson, M.D., Superintendent, Fulton State Hospital, Fulton, Mo. C. V. Mosby Co., St. Louis, Mo. 1965. 134 pages. Price: $8.50.

HANDBOOK OF CLINICAL LABORATORY DATA

Editor, Henry C. Damm, Ph.D., Western Reserve University; Chairman, Advisory Board and Associate Editor, John W. King, M.D., Ph.D., The Cleveland Clinic Foundation (Ohio). The Chemical Rubber Co., Cleveland, O., 44114. 1965. 469 pages. Price: $12.50.



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1965 **Wisconsin**

Sept. 24: Postgraduate course in cancer chemotherapy sponsored by University of Wisconsin extension division, Wisconsin Center, Madison.

Sept. 25: 11th annual fall cancer conference, the "Cancer Scrimmage," sponsored by Wisconsin Division of American Cancer Society and University of Wisconsin Medical School, Wisconsin Center, Madison.

Sept. 30: UW Annual Pediatric Day, sponsored by University of Wisconsin extension division, Wisconsin Center, Madison.

Oct. 6–8: Wisconsin Nurses Association annual convention, Hotel Sheraton–Schroeder, Milwaukee.

Oct. 8: House of Delegates of State Medical Society of Wisconsin, fall interim meeting, SMS headquarters, Madison.

Oct. 13–14: Postgraduate course, "Clinical Application of Current Concepts in Renal Pathophysiology," University of Wisconsin, Madison.

Oct. 15: Wisconsin Society of Internal Medicine, morning postgraduate course on "Chronic Dialysis and Renal Transplantation," followed by annual meeting and scientific program, Wisconsin Center, Madison.

Oct. 16: American College of Physicians, midwest regional meeting, Wisconsin Center, Madison.

Oct. 16: Conference on "Rh Problems and the Sensitized Mother," Marquette University, University of Wisconsin, and Wisconsin Obstetrical–Gynecological Society, State Medical Society headquarters, Madison.

Oct. 20: Racine–Kenosha Chapter of Wisconsin Academy of General Practice, Eli Lilly symposium, Wingspread auditorium, Racine.

Oct. 29: National Rehabilitation Association, national conference, Hotel Sheraton–Schroeder, Milwaukee.

Oct. 29–30: Symposium on "Integration of Social Science Concepts in Psychotherapy," co-sponsored by Milwaukee Sanitarium Foundation and Department of Psychiatry, Marquette University School of Medicine, Coach House Motor Inn, Milwaukee.

Nov. 4: "In Depth" teaching program, "Problems Encountered in Aging Process" (Psychiatric), sponsored by University of Wisconsin Medical School, State Medical Society, and Madison Chapter of Wisconsin Academy of General Practice, SMS headquarters, Madison.

Nov. 4–5: Symposium on epilepsy, auspices of Department of Neurology, University of Wisconsin Medical School, Wisconsin Center, Madison.

Nov. 4, 11, 18–Dec. 2: Course in fluid and electrolyte therapy given by Marquette University School of Medicine in cooperation with Milwaukee Children's Hospital, Amphitheater, Milwaukee Children's Hospital, 1700 W. Wisconsin Ave., Milwaukee.

Nov. 11–13: The Medical Society of Milwaukee County, Milwaukee medical conference, Coffey Auditorium, Milwaukee County Hospital.

Nov. 12–14: Wisconsin Society of Pathologists, annual meeting, held jointly with North Central Region of College of American Pathologists, Wisconsin Society of Medical Technologists and Wisconsin Radiological Society, Marquette University, Mamie's Grotto, and Coach House Motor Inn, Milwaukee.

Nov. 19: Mount Sinai Hospital, 4th annual medical-industrial symposium, Hotel Pfister Grand Ballroom, Milwaukee.

Dec. 1: "In Depth" teaching program, "Problems Encountered in Aging Process" (Medicine), SMS headquarters, Madison.

1966

Jan. 20: "In Depth" teaching program, "Problems of Elderly Patients" (Surgery and Anesthesia), SMS headquarters, Madison.

Feb. 16: "In Depth" teaching program, "Problems of Elderly Patients" (Dermatology and EENT), SMS headquarters, Madison.

Mar. 9, 16, 23, 30: Marquette University School of Medicine, postgraduate course in hematology, Milwaukee.

Mar. 24: "In Depth" teaching program, "Problems of Elderly Patients" (Neurology), SMS headquarters, Madison.

Mar. 31–Apr. 2: University of Wisconsin extension division, "Virus Diseases of Childhood," Wisconsin Center, Madison.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 7, 14, 21, 28: Marquette University School of Medicine, postgraduate course on chemotherapy of infectious diseases, Milwaukee.

May 5–7: University of Wisconsin extension division, "Radiology and Pathology of Genitourinary System," Wisconsin Center, Madison.

May 10–12: State Medical Society, annual meeting, La Crosse.

May 21: Wisconsin Heart Association, 18th annual meeting, Wisconsin Center, Madison.

June 17: Wisconsin Academy of General Practice, Lederle symposium, Wausau Club, Wausau.

1965 **Neighboring States**

Oct. 11–13: Academy of Psychosomatic Medicine, annual meeting, Sherman House, Chicago. Joint morning meeting and luncheon Oct. 11 with American Society of Clinical Hypnosis.

Oct. 12–13: Chicago Medical School Department of Psychiatry, medical-dental workshop on hypnosis and psychiatry, Hotel Sherman, Chicago.

Oct. 13: Department of Psychiatry and Neurology, Chicago Medical School, start of postgraduate courses in psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists.

Oct. 18–22: American College of Chest Physicians, postgraduate course No. 1, "Clinical Application of Cardiopulmonary Physiology," Knickerbocker Hotel, Chicago, Ill.

Oct. 20, Nov. 3, 17, Dec. 1, 15: Mount Sinai Hospital Medical Center of Chicago, symposium on management of chronic disease patient, sponsored by USPHS at Mount Sinai Hospital, Chicago.

Oct. 22–23: American Association of Automotive Medicine in cooperation with Mayo Clinic and Mayo Foundation, program relating to automotive safety and accident prevention, Mayo Clinic, Rochester, Minn.

Oct. 23–28: American Academy of Pediatrics, 34th annual meeting, Palmer House, Chicago.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30–Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Nov. 5: International College of Surgeons, divisional meeting, Urbana, Ill.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI conference on obstetric, gynecologic, and neonatal nursing, Pick–Congress Hotel, Chicago, Ill.

Nov. 11–13: Ancker Hospital (Saint Paul–Ramsey Hospital), inaugural scientific program including two days of general medical meetings and one-half day specialty meetings, St. Paul, Minn.

Nov. 12: Diabetes Association of Greater Chicago, 8th annual symposium on diabetes, Bigler Auditorium, Children's Memorial Hospital, Chicago.

Nov. 19–22: National Society for Crippled Children and Adults, annual convention, Palmer House, Chicago, Ill.

1965 **AMA**

Nov. 28–Dec. 1: AMA 19th clinical convention, Philadelphia, Pa.

1966

Feb. 4–9: AMA Medical Education Congress.

June 26–30: AMA Annual Convention, Chicago.

Nov. 27–30: AMA Clinical Convention, Las Vegas.

Special Program on Rh Oct. 16

The Wisconsin Society of Obstetrics and Gynecology, in cooperation with the Gynecology and Obstetrics Departments at the University of Wisconsin Medical School and Marquette University School of Medicine, is presenting a special one-day program on "Rh Problems and the Sensitized Mother" Saturday, October 16, in Madison.

Guest speakers from out of the state will be Dr. Lewis Diamond, Boston, and Dr. John M. Bowman, Winnipeg, Canada. Other speakers will be Dr. A. L. Kennan, associate professor of gynecology and obstetrics at the University of Wisconsin; Dr. Herbert F. Sandmire, Green Bay, and Dr. Richard F. Mattingly, professor and chairman of the Department of Gynecology and Obstetrics at Marquette.

The full day conference, at the State Medical Society headquarters, will consider intrauterine transfusions, amniocentesis on Rh sensitized women, amniotic fluid analysis in Rh sensitization, metabolism of biliary pigments, and management of the Rh sensitized mother and the erythroblastic infant.

Members of the Wisconsin Society of Obstetrics and Gynecology will be admitted without fee (other than a $2.00 luncheon charge), while all non-member physicians may attend at a registration of $5.00, including lunch.

The program has been cleared so that all AAGP members attending will receive educational credit (5 hours).

All registrations are to be directed to the State Medical Society, Box 1109, Madison, Wis. 53701, and checks made payable to the CES Foundation.

Wisconsin Nurses Association Convention

Registered professional nurses from all over the state will converge on the Hotel Sheraton–Schroeder, Milwaukee, October 6–8 for the 1965 convention of the Wisconsin Nurses Association.

The theme is "In Search of Togetherness for Nursing Excellence." Mrs. Elizabeth A. Regan, R.N., associate professor of nursing, University of Wisconsin Extension Division, Milwaukee, is WNA president, and will welcome nurses to the convention Wednesday morning, October 6.

The Speakers include: Cornelius L. Golightly, Ph.D., associate professor of philosophy, University of Wisconsin–Milwaukee, speaking on "The Dilemma in Education Today;" Dr. Melvin Sabshin, chairman of the Department of Psychiatry, University of Illinois, Chicago, "An Interdisciplinary Approach to the Care of the Ill;" Mrs. Marie S. Andrews, R.N., chairman of the department of nursing, graduate school, Boston College, Chestnut Hill, Mass., "Why Do Educators Need to be Practitioners?".

Convention goers will have their choice of six nursing clinics, which have proved increasingly popular in recent years. Speakers and their topics include: Florence Blake, R.N., professor of pediatric nursing, University of Wisconsin School of Nursing, Madison, "Kathy's Behavior Communicated Her Needs;" Dr. Edgar End, Milwaukee, "Hyperbaric Oxygenation;" Jane Kennedy, R.N., assistant professor in the master's program, Loyola University, Chicago, "The Nurse's Role in Cardiovascular Nursing;" Otto F. Schlaak, Ph.D., station manager of WMVS–TV, Milwaukee, "Programmed Instruction;" Mrs. Jean Barreras, R.N., psychiatric nursing consultant, Division of Mental Hygiene, State Department of Public Welfare, Madison, and Lorraine C. Haasch, R.N., director of nursing, Muirdale Sanatorium, Wauwatosa, who will share a discussion on "Nursing Care Plans in Nursing Homes."

Students at Alverno College of Nursing, Milwaukee, under the direction of Sister Marie Albert, R.N., will present "3 Maple Street," a play about public health nursing which will be a feature of the last nursing clinic.

A president-elect, second vice-president, treasurer, plus three directors and two members of the committee on nominations will be elected.

All registered professional nurses in Wisconsin, as well as student nurses, are welcome to attend. For registration blanks, write the Wisconsin Nurses Association, 161 W. Wisconsin Ave., Room 6012, Milwaukee, Wis. 53203.

5th Milwaukee Medical Conference

The fifth annual Milwaukee medical conference, sponsored by The Medical Society of Milwaukee County and slated for November 11–13 at Milwaukee County Hospital, is being planned as a postgraduate course, Dr. Leonard W. Worman, program committee chairman, has announced. It will offer a consideration of present concepts of diagnosis by a faculty of pathologists, radiologists, internists, pediatricians, and surgeons.

The conference will begin Thursday morning, November 11, at Coffey Auditorium, Milwaukee County Hospital. From 9 a.m. until noon, diagnosis by special techniques will be considered. The program will continue as follows: 1–5 p.m. November 11—Diagnosis—the art of modern medical science; November 12: 8–10:30 a.m.—Ward rounds—Bedside teaching by guest faculty; 10:30 a.m.–12:30 p.m.—Diagnosis of pediatric problems; 1:30–5 p.m.—Diagnosis—specific regions and organ system; November 13: 9–11 a.m.—Diagnosis in special circumstances.

Various alumni groups are planning special events for the evenings, and the usual reception will be held to permit those attending the conference to meet the guest faculty.

Marquette Postgraduate Courses

Marquette University School of Medicine has announced its program of postgraduate courses in medical education for the period beginning July 1, 1965, and ending June 30, 1966.

In cooperation with Milwaukee Children's Hospital, the University will present a course in fluid and electrolyte therapy from 7:30 to 9:30 on four

Thursday evenings, November 4, 11, and 18 and December 2, in the Amphitheater of Milwaukee Children's Hospital, 1700 West Wisconsin Avenue, Milwaukee. The programs will be "Normal and Abnormal Water Needs," November 4; "Normal and Abnormal Electrolyte Needs," November 11; "Disturbances of Acid Base Balance," November 18, and "Some Common Problems and Their Management," December 2. Co-directors of the course will be Dr. Gerald A. Kerrigan, dean of the School of Medicine and associate professor of pediatrics, and Dr. Edward J. Lennon, assistant professor of medicine and director of clinical research.

The program is acceptable for 10 accredited hours by the American Academy of General Practice. Tuition is $25.00 but there is no charge for residents, interns, or medical students.

Reservations should be sent to Joseph W. Rastetter, M.D., Director: Postgraduate Medical Education Programs, Marquette University School of Medicine, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

Dr. A. V. Pisciotta will direct a course in hematology from 7:30 to 9:30 p.m. Mar. 9, 16, 23, and 30, 1966, and also planned for March is a course in gynecology and obstetrics under the direction of Dr. Richard F. Mattingly.

From 7:30 to 9:30 p.m. Apr. 7, 14, 21, and 28, 1966, Dr. B. A. Waisbren will direct a course on the chemotherapy of infectious diseases.

Chicago Postgraduate Program

A postgraduate program aimed at increasing the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy will be offered by the Department of Psychiatry and Neurology of The Chicago Medical School beginning October 13. The program has been planned to meet the growing need of general practitioners and physicians other than psychiatric specialists, for further training and experience in the areas of psychiatric diagnosis and treatment.

Further information may be obtained from Bernard Block, M.D., Director—Continuing Education, Dept. of Psychiatry and Neurology, Chicago Medical School at Mt. Sinai Hospital, 2755 W. 15th St., Chicago, Ill. 60608.

National Rehabilitation Conference

Dr. George A. Hellmuth, associate professor of occupational and environmental medicine at Marquette University School of Medicine, will address one of the sessions of the National Rehabilitation Association's national conference October 29 at the Hotel Sheraton–Schroeder, Milwaukee.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS PLANS EDUCATIONAL SEMINAR

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In addition to the symposium on office management, your assistant will also hear talks on: "The Patient—The Office VIP;" "Medical Quackery;" and "Medical Who-dun-its." The latter will be presented by Milton Helpern, M.D. chief medical examiner, New York City.

The House of Delegates, AAMA's policy-making body, will convene Wednesday, October 13, and continue through Thursday, October 14. Friday and Saturday are devoted to the educational programs, with association workshops highlighting the Saturday proceedings. Featured workshop topics will be: Parliamentary procedure; certification; membership; leadership; public relations and treasurers.

Prior to the formal opening of the meeting, special tours and events have been arranged for the medical assistants. Monday October 11 is "Medical Assistants Day at the World's Fair" with a VIP tour of the GE Futurama, a visit to the Atomedic Hospital, and brunch at the Top of the Fair. Special admission to other exhibits has been arranged.

During a visit to the UN on Tuesday, October 12, AAMA delegates will hear a special message from a member of the World Health Organization. A tour of Rockefeller Center, featuring a Fiesta Brunch at La Fonda del Sol, highlights Wednesday morning.

On Friday, October 15, AMA President James Z. Appel, M.D., Lancaster, Pa., will be the guest speaker at a luncheon honoring AAMA past presidents. The Awards luncheon Saturday will honor those medical assistants who have become certified, as well as state chapters which have been judged outstanding in the areas of membership and publications. Scholarship fund certificates will also be presented.

Climaxing the week's events will be the Saturday banquet honoring state chapter presidents. At that time, AAMA President, Mrs. Rose Merritt, Savannah, Ga., will present the outstanding merit and honorary membership awards, and Miss Marge Slaymaker, Newton, Kan., will be installed as 1965–1966 president.

"Problems Encountered in the Aging Process"

CORE OF NEW U. OF W. PROGRAMS

Special problems associated with care of the elderly patient will be covered in a series of one-day teaching programs at the University of Wisconsin and State Medical Society Headquarters between November 1965 and March 1966. The programs, developed cooperatively with the Madison Chapter of the Wisconsin Academy of General Practice and the Division on Aging of the Commission on State Departments, State Medical Society, will consist of patient demonstrations and lectures on a variety of subjects of interest to the family physician.

"In planning these programs," said Dr. Adolph Hutter, Fond du Lac, chairman of the Division on Aging, "we recognized that many new advances have been made in the care of the elderly, and those of us concerned with this problem are grateful that the University of Wisconsin Medical School has agreed to provide a series of related teaching programs in this important area of medical practice. While one of the active sponsors is the Wisconsin Academy of General Practice, it should be emphasized that these programs are open to and directly aimed at, *every physician who cares for elderly patients.*"

Dates and areas of discussion will be:

THURSDAY, NOV. 4: Psychiatric Problems of the Elderly Patient

Recognition, management and prognosis of depression in the post-climacteric period; psychoses of the elderly; psychiatric management of arteriosclerotic cerebral vascular disease and related conditions; use of drugs, psychotherapy, and physical therapy in the elderly.

WEDNESDAY, DEC. 1: Special Medical Problems of the Elderly Patient

The elderly diabetic, osteoporosis and osteoarthropathy, optimal nutrition in the elderly, respiratory problems, and the use of drugs in the elderly.

THURSDAY, JAN. 20: Surgery and Anesthesia in the Elderly Patient

Preoperative, operative, and postoperative care of an elderly patient requiring abdominal surgery as an elective and as an emergency procedure will be discussed. Special problems of anesthesia in the elderly, and complications, will be dealt with by closed-circuit TV from the operating room at University Hospitals. Fluid balance and certain urological problems will also be covered.

WEDNESDAY, FEB. 16: Special Dermatological and E.E.N.T. Problems of the Elderly Patient

This program will be directed toward the recognition and management of special dermatological, ophthalmological, hearing problems commonly seen in elderly patients by the family physician.

THURSDAY, MARCH 24: Neurological Problems of the Elderly Patient

Cerebrovascular disease will be covered by way of a short review of the pathologic processes, followed by demonstrations of cases. The afternoon will be devoted to a review of radiologic demonstrations of cerebrovascular disease, the role of EEG in diagnosis, the medical and surgical aspects of therapy, and the rehabilitation of patients with cerebrovascular disease.

With support from the Wisconsin State Board of Health and the Postgraduate Teaching Program of the Merck Sharp and Dohme Company, these programs will be provided for a charge of $5.00 per meeting *(including lunch and parking)*, or $20.00 for the entire series of five.

Following the pattern of previous years, these conferences will begin with "wet clinics" at University Hospitals, Madison, at 10 a.m., followed by lunch and an afternoon lecture program at the State Medical Society Headquarters. All conferences will close by 3:30 or 4 p.m.

Those desiring to enroll are asked to please send reservations to the State Medical Society on the form below. *Make checks payable to the CES Foundation.*

see opposite page for enrollment form

Meeting at Mayo Clinic

All physicians are invited to attend a medically oriented program relating to automotive safety and accident prevention October 22 and 23 at the Mayo Clinic, Rochester, Minn. The meeting is sponsored by the American Association of Automotive Medicine in cooperation with the Mayo Clinic and Mayo Foundation.

For registration, write: Postgraduate Courses, Mayo Clinic, Rochester, Minn. 55902. Registration fee is $20.00.

Ancker Hospital Inaugural Program

Dr. Martin Cummings, director of the National Library of Medicine, will give the principal address at the inaugural scientific program of the new Ancker Hospital (Saint Paul–Ramsey Hospital) November 11–13 at St. Paul, Minn. Other guest speakers are all Ancker alumni. Current staff members of the hospital and University of Minnesota faculty will be the other participants in the program, which will include two days of general medical meetings and a half day of specialty meetings.

An invitation is extended to all physicians. Further information may be obtained by writing James F. Hammarsten, M.D., Chief of Medicine, Ancker (Saint Paul–Ramsey) Hospital, St. Paul, Minn.

Medical–Industrial Symposium

Mount Sinai Hospital, Milwaukee, will present its fourth annual medical-industrial symposium Friday, November 19, in the new Grand Ballroom of the Hotel Pfister, Milwaukee. Topic at the morning session will be "Industrial Post–Traumatic Neurosis" and at the afternoon session, "Interpretation of 'Injury' Under the Wisconsin Workmen's Compensation Act." Gov. Warren P. Knowles will introduce these timely and significant subjects.

Advance registration is necessary by October 15. A fee of $10.00 will include attendance at both sessions, lunch at the Hotel Pfister, and a copy of the transactions.

The program should appeal to a large number in the medical and legal professions as well as management, labor, and government. Participating speakers include Dr. Milton H. Miller, Madison, chairman of the Department of Psychiatry at the University of Wisconsin Medical School and director of the Wisconsin Psychiatric Institute; Dr. Henry A. Davidson, superintendent of Essex County Overbrook Hospital in New Jersey and author of the textbook, "Forensic Psychiatry;" the Hon. Edwin M. Wilkie, judge of the Dane County Circuit Court; Dr. Francis J. Millen, Milwaukee, associate clinical professor of neuropsychiatry at Marquette University School of Medicine; Dr. David J. Ansfield, attending orthopedist at Mount Sinai Hospital and chairman of the symposium committee; Milwaukee attorneys, Robert E. Gratz and Clayton R. Hahn, and Ralph E. Gintz of Madison, director of the Wisconsin Workmen's Compensation Division since 1956.

Hypnosis and Psychiatry Workshop

Following the annual scientific meeting of the American Society of Clinical Hypnosis, the Chicago Medical School Department of Psychiatry will sponsor a medical-dental workshop on hypnosis and psychiatry at the Hotel Sherman in Chicago.

The basic section, on Tuesday, October 12, will introduce clinical hypnosis to the novice and also serve as a review for those already initiated. Many demonstrations and practice inductions are slated.

The advanced section on October 13 is designed to give a broader background in psychodynamics and various forms of psychotherapy, including hypnotherapy.

Annual Symposium on Diabetes

The Diabetes Association of Greater Chicago will conduct its eighth annual symposium on diabetes Friday, November 12, at the Bigler Auditorium, Children's Memorial Hospital, 707 West Fullerton, Chicago, with registration beginning at 8:30 a.m.

The morning session will be devoted to a symposium on current definitions of the disease, in-

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THURSDAY, MARCH 24—NEUROLOGY _____ ☐

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cluding electron microscopical, biochemical, endocrinological, and clinical redefinitions, followed by a panel discussion. In the afternoon there will be a presentation on the prevalence and epidemiology of diabetes, a discussion of psychiatric aspects, and a paper on juvenile diabetes and some of the information that may be drawn from the work in this area.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members. The fee for nonmembers is $25.00. Members of the Academy of General Practice may claim hour for hour credit in Category II.

Inquiries may be addressed to: The Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago 11, Ill.

Symposium on Hodgkin's Disease

The latest clinical and research information on Hodgkin's disease will be presented at a symposium cosponsored by the American Cancer Society and the National Cancer Institute November 22 at the New York Hilton Hotel, New York City. The clinical management of Hodgkin's disease will be emphasized at this program, which all interested physicians, medical students, and investigators are invited to attend. There is no advanced registration or registration fee.

Further information may be obtained by writing Jack W. Milder, M.D., Research Department, American Cancer Society, Inc., 219 E. 42 St., New York, N.Y. 10017.

American Thoracic Society Meeting

The 1966 annual meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, will be held May 23–25, 1966, in San Francisco, Calif.

Papers to be presented will be selected from abstracts submitted prior to Jan. 6, 1966. These should be sent to James Kieran, M.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York, N.Y. 10019.

Conference on Medical Aspects of Sports

The seventh national conference on the medical aspects of sports, sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held November 28 at the Benjamin Franklin Hotel in Philadelphia, Pa. The conference is held annually in conjunction with and on the first day of the clinical convention of the American Medical Association. In addition, the conference will be held in cooperation with the observance of the bicentennial anniversary of the University of Pennsylvania's School of Medicine and of medical education in the United States.

As was true of the previous six conferences, the seventh will cover a wide range of subjects of interest to physicians, especially those serving school and college sports programs. Included will be papers, panels, and discussions relating to readiness for sports participation, management of health problems in sports, and application of research to injury prevention.

Those interested in receiving further information should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

ACOG District, Nursing Conferences

The schedule for 1965 district meetings and conferences on obstetric, gynecologic and neonatal nursing has been completed by the American College of Obstetricians and Gynecologists.

The District V meeting and nursing conference will be held concurrently October 28–31 at Hotel Cleveland, Cleveland, O. The District VI meeting is scheduled for October 28–30 at the Kahler Hotel, Rochester, Minn. The District VI nursing conference will take place November 10–13 at the Pick–Congress Hotel, Chicago, Ill.

These annual sessions have become an important part of the College's continuing education program for physicians and nurses. The district meetings are open to all interested physicians regardless of whether they are fellows of the College and the nursing conferences may be attended by all nurses who wish to advance their education in the specialty.

Pan-Pacific Surgical Association

The board of trustees of the Pan-Pacific Surgical Association has announced the dates of the tenth congress of the Association and the second mobile educational seminar to countries bordering on the Pacific basin.

Part I will convene at the Princess Kaiulani Hotel in Honolulu, Hawaii, Sept. 20, 1966, and continue through September 28. Part II and Part III will depart Hawaii September 28 and travel to Japan and Hong Kong, with Part II returning to San Francisco, Calif., October 10 in time for the opening of the American College of Surgeons, and Part III continuing on to the Philippines, Thailand, India, Singapore, Australia, and New Zealand, returning to Hawaii November 1.

The congress offers an extensive scientific program presented by more than 300 leading surgeons from all parts of the world in nine different surgical specialties and related specialties: general surgery, ophthalmology, otolaryngology, thoracic cardiovascular surgery, neurosurgery, obstetrics and gynecology, orthopedics, plastic surgery, urology, anesthesiology, and radiology. All physicians are invited to attend and participate.

Further information may be obtained by writing: Pan-Pacific Surgical Association, Room 236, Alexander Young Building, Honolulu, Hawaii 96813.

Clinical Pharmacologic Seminar

A postgraduate course in two parts, "Clinical Pharmacologic Techniques," will be presented during the first half of 1966 under the sponsorship of the Section of Clinical Pharmacology, Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa., and the American Therapeutic Society. The course will be held at the Marriott Motor Hotel, Philadelphia, Part I on January 24–28 and Part II May 16–20.

The course will be somewhat changed from a similar course given in February 1963. About 80 per cent of the topics will be material not covered previously. Subjects which will be repeated are in areas where there has been considerable recent advancement. The program will be aimed directly at clinical pharmacologists working in industry, academic institutions, and hospitals to provide a comprehensive background for use in their research.

Registration fee will be $100 for either part of the course or $175 for the combined course. Registration will be limited to 120 researchers.

Obstetrics, Gynecology Seminar Cruise

Open to all physicians, regardless of their place of residence, is the first obstetrics and gynecology seminar cruise which will be offered Feb. 28-Mar. 4, 1966, by the Department of Obstetrics and Gynecology, College of Medicine, University of Florida. Physicians who enroll will cruise the Atlantic and Bahama waters aboard the S. S. ARIADNE, sailing from Fort Lauderdale (Port Everglades).

On the faculty for the seminar, which is approved by the Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice, are Dr. Nicholas J. Eastman, professor emeritus, Department of Obstetrics, Johns Hopkins University School of Medicine, Baltimore, Md., and Dr. S. Leon Israel, professor, Department of Gynecology and Obstetrics, University of Pennsylvania School of Medicine, Philadelphia.

Subjects to be considered are amenorrhea, toxemia of pregnancy, sterility, obstetric anesthesia and analgesia, dystocia due to anomalies of the expulsive forces, hirsutism, diabetes mellitus in pregnancy, and dysfunctional uterine bleeding of puberty and childbearing age.

Brochures containing details on cruise reservations may be obtained from: E. M. Baskette, Eastern Steamship Line, P. O. Box 882, Miami, Fla. 32101.

The registration fee of $25.00 may be paid during the registration hour aboard the S. S. ARIADNE, or checks (made payable to the University of Florida) may be sent to the Division of Postgraduate Education, University of Florida College of Medicine, Gainesville, Fla., prior to the sailing date of Feb. 28, 1966.

Symposium on Chronic Disease Patient

At the invitation of the United States Public Health Service, Mount Sinai Hospital Medical Cener of Chicago is presenting a symposium on the management of the chronic disease patient. One of four sponsored by the USPHS, the symposium will be the only one offered in the Midwest.

Five full-day seminars will be presented. The first, on "Chronic Obstructive Lung Disease," with Dr. Albert Haas as guest speaker, is scheduled for October 20. The others will be "Cardiac Disabilities," Dr. C. Walton Lillehei, November 3; "CVA-Stroke," Dr. Clark H. Millikan, November 17; "Arthritis and Orthopedic Disabilities," Dr. Edward Compere, December 1; and "Degenerative Neurological Diseases," guest speaker to be announced, December 15.

For further information and registration, contact: Aaron M. Rosenthal, M.D., Chairman, Dept. of Physical Medicine and Rehabilitation, Mount Sinai Hospital Medical Center, California Ave. at 15th St., Chicago, Ill. 60608.

AMA Clinical Convention

A comprehensive scientific program, a new postgraduate course, and special clinical workshops are among the features of the American Medical Association's 19th clinical convention November 28–December 1 in Philadelphia.

Topics to be covered during a scientific program designed to hold special interest for the practitioner include ulcerative colitis, gram-negative bacterial infections, a medical–surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

Outstanding teachers will conduct the clinical workshops on diabetes, heart examination, management of common eye problems, and solution of selected diagnostic and therapeutic problems. Practicing physicians will be able to participate in this new convention feature.

Also new will be a postgraduate course in cardiovascular therapeutics, which will be offered in addition to the course on gynecology and obstetrics begun at the clinical convention last year in Miami.

Twelve fireside conferences planned for Sunday evening, November 28, at the Warwick Hotel, will be joint sessions of the American College of Chest Physicians and the AMA.

There will be approximately 100 scientific exhibits, and 30 medical motion pictures. Color television will be presented at the Civic Center in cooperation with the Hospital of the University of Pennsylvania. The convention is being held in conjunction with the 200th anniversary observance of that university's School of Medicine, which is the nation's oldest. Physicians and their families will be able to participate in ceremonies observing the school's founding. They will also have opportunities to visit other parts of historic Philadelphia.

For information on registration, those interested may write: Circulation and Records Dept., American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

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The Cause and Treatment of Low Back Pain During Pregnancy

By JACK D. SPANKUS, M. D., M. Sc., Milwaukee, Wisconsin

■ MINOR DISCOMFORT in the back during pregnancy is frequently accepted as being normal. The pain may be disabling, especially during the last trimester of pregnancy. It may reduce an otherwise productive woman to inactivity and, at times, confinement to bed. The pregnant woman can have any back problem to which the nonpregnant woman is subjected. Pain of any intensity during pregnancy usually causes apprehension in the patient. The most significant change during pregnancy which predisposes the woman to backache is the rotation of the pelvis with forward displacement of the center of gravity. This exaggerates the normal lumbar curve. To compensate for this change, the pregnant woman throws her shoulders back and straightens her head and neck.[1] The diagnosis of backache due to sacroiliac instability has fallen into disrepute, since the sacroiliac joint is among the most stable joints in the body, even with hormonal relaxation.

Hormonal relaxation may account for a small percentage of symptoms in backache during pregnancy. The hormonal factor which causes softening of the supporting and connecting tissues will allow the symphysis pubis to widen from 1 to 12 mm.[2] The relaxation of the pubis symphysis will cause rotatory stress on the sacroiliac joint.[5] These symptoms are characterized by location of pain over the posterior iliac spine and over the symphysis pubis. The pain is aggravated with activity and by pelvic compression or distraction. A low circumferential pelvic binder, low-heeled shoes, and bed rest will alleviate the symptoms. With severe pain, bed rest in a pelvic sling is effective. The bed board is unsatisfactory and intolerable because of the exaggerated lordosis.

The most common cause of back pain is faulty body mechanics.[4] The discomfort may first appear in the fifth month of pregnancy, upon arising in the morning. There is increasing discomfort in the latter part of the day with some relief upon recumbency. The cause of the pain is poor posture, aggravated by relaxation of the abdominal muscles, and an increasing pendulous abdomen with forward rotation of the pelvis. The rapidity of the physiologic postural changes on the already abnormal posture causes an unusually severe stress on the ligaments and muscular attachments. Treatment consists of abdominal and back exercises, including posture training. The patient should have frequent short rest periods with the knees slightly flexed. Unfortunately this treatment is usually unsuccessful because the patient is seldom adequately instructed in the exercises, or, she is not impressed by the importance of the exercises. A properly fitted maternity orthopedic garment is of temporary relief during the early stage of pregnancy.

Traction or pressure on the spinal nerves will cause pain as the nerves course through the pelvis. The nerves commonly affected are the iliofemoral, ilioinguinal, and the sciatic and sacral plexes.[3] Pressure on the iliofemoral and ilioinguinal nerves may begin in the fifth month, but more often starts in

the seventh month of pregnancy. The symptoms are characterized by pain radiating from the back along the lower abdomen and anterior medial aspect of the upper thigh. Relief of the pain can be obtained by recumbency, lumbosacral support and occasional injection of the trigger area with procaine.

If low back pain with sciatica occurs during the last trimester of pregnancy, it may be caused by a protruded lumbar disk or by compression of the fetus on the lumbosacral plexes. Usually neurological changes accompany the herniated disk with paresthesias of the involved dermatome and absent deep tendon reflexes. This is not generally true for compression of the lumbosacral plexes. If the patient has had symptoms from a herniated disk prior to her pregnancy, increased symptoms may be expected during her pregnancy. Surgery is contraindicated during the pregnancy for a herniated disk, except if there is loss of bladder and bowel sphincter control. Then, immediate surgery is mandatory.[2] Electromyography may be done to confirm the diagnosis of a herniated disk. Myelography should be done only if there is clinical evidence of a neoplasm.

Usually the symptoms of low back pain and sciatica can be relieved by elevating the foot of the bed, thereby allowing the head of the fetus to slip out of the pelvis and the uterus to fall upwards. This relieves local compression on the lumbosacral plexes and reduces venous congestion. Bedboards are seldom tolerated because of the lordosis in the pregnant patient. A pillow under the knees and under the painful area of the back is more effective. Pelvic traction is not tolerated due to the pressure on the lower abdomen and poor fit of the traction corset over the enlarging abdomen. Bilateral leg traction frequently causes skin irritation and phlebothrombosis. The patient is seldom comfortable because of the confinement of her legs and the pull exerted through her knee joints. Pain may also occur in the anterior thigh from traction on the tight hip flexors.

Conditions often aggravated by pregnancy are congenital anomalies such as spondylolisthesis and spondylolysis which cause the back to be unstable. The supporting ligaments are susceptible to the increased burden and result in muscular and ligamentous strain. Asymmetric facets at the lumbosacral joint exist when one of the lumbosacral apophyseal joints is in the coronal plane and the others in the sagittal plane. This deprives the lumbosacral joint of its rotary motion. An abnormally long transverse process of the fifth lumbar vertebra, which causes sacralization, will reduce lumbosacral mobility. Fractures, acute sprains, infections, arthritis, neoplasms, as well as abdominal and pelvic pathology, should also be considered in the cause of low back pain during pregnancy.

Summary. The common causes of backache during pregnancy have been reviewed. Limited x-ray evaluation should be done and then only after the first trimester. Myelograms are contraindicated except where there is clinical evidence of a neoplasm. Surgery during pregnancy is also contraindicated except in the presence of a herniated disk with bowel and bladder sphincter incontinence.

Most back and sciatic syndromes can be relieved with limited physical activity, low-heeled shoes, bed rest, thermotherapy and back support after the first trimester. Bed boards, traction, and placing the patient in bed in the Fowler's position, with the spine, hips, and knees flexed, are usually intolerable. Rather, place a pillow under the knees and the painful area of the back. Muscle relaxants are seldom effective. As soon as there is remission of the pain, it is advisable to begin posture exercise to increase the tone of the back and abdominal musculature.

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THE AMERICAN FOUNDATION for Pharmaceutical Education has, for the 24th year, awarded college grants to students in pharmacy colleges. Eighty students received awards this year. Over the 24 years, awards totaling $3.7 million have gone to some 3140 students. Most of the funds are donated by the pharmaceutical industry.

Rhabdomyosarcoma in a Giant Diverticulum of Urinary Bladder with Metastasis

By SHAFIK F. RICHANY, M.D., Milwaukee, Wisconsin

■ RHABDOMYOSARCOMA arising in a giant diverticulum of urinary bladder constitutes a unique dual pathology. Although diverticulosis (congenital or acquired) of urinary bladder is common and cases of leiomyosarcoma and undifferentiated sarcoma arising in a vesical diverticulum have been documented in the literature, the occurrence of a rhabdomyosarcoma has not been previously reported.[1-25] However, nondiverticular rhabdomyosarcoma (sarcoma botryoides) of the urinary bladder, occurs predominantly in male children and infants. Extraurogenital sarcoma botryoides has been reviewed by Horn et al[26] and Farinacci and associates.[27]

Primary carcinomas in vesical diverticulum have been reported numerous times.[4, 28-33] Mayer reviewed Mayo Clinic cases between 1894–1947 and found 25 cases fitting the criteria of epithelial neoplasms. Carcinoma in urinary bladder diverticulum associated with calculus has been reported by New and Allerman[34] and Petkovic.[35] Other reports dealing with primary carcinomas of vesical diverticulum appeared in recent literature.[36-42] The literature on primary epithelial neoplasms, benign and malignant, complicating urinary bladder diverticulum with statistical analysis of collected cases, includes reports by Abeshouse and Goldstein,[28] Smith and Suder[43] among others. These reports indicate that undifferentiated and squamous cell carcinomas are the commonest malignant epithelial tumors.

The case reported here is histologically an authentic rhabdomyosarcoma, adult type, arising in a giant diverticulum of urinary bladder in a 74-year-old white man. Metastases were present in the lungs, pleura, and diaphragm.

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Case Report. The patient was a 74-year-old white man, a retired painter, with kyphoscoliosis dating to childhood. He was admitted with a chief complaint of gross hematuria of one month's duration. Associated symptoms of "trouble passing urine," nocturia 4 to 5 times per night, hourly frequency during daytime, dysuria, urgency, and mild sensation of suprapubic discomfort were present. During the past 18 months of his life, he noted mild exertional dyspnea and recurrent pedal edema. Orthopnea and cough were denied.

Past medical history disclosed two previous admissions to this medical center. In November 1951 he had a right spermatocelectomy and small cysts were removed from the left epididymis. His postoperative course was complicated by thrombosis of deep veins of the left leg, which subsequently led to surgical ligation of the left common femoral vein. In January 1952 he had right inguinal herniorrhaphy.

Physical examination on his last admission revealed a 74-year-old white man, well developed, fairly well nourished, cooperative, alert, and in no acute distress. His temperature was 99.4 F., pulse rate 88 with normal sinus rhythm. A2 was accentuated. Blood pressure was 160/90 mm Hg. Head and neck were normal except for many missing teeth. His chest showed increase in AP diameter and thoracic dexterokyphoscoliosis. The diaphragm was fixed, with diminished excursions bilaterally. Both lung fields revealed expiratory wheezes. X-ray studies of chest showed considerable scoliosis, but the pulmonary fields were free of active disease. The liver was two fingerbreadths down on deep inspiration. Suprapubic tenderness was elicited on deep palpation. A 2.5-cm hydrocele or spermatocele was palpated in the distal cord on the right; on the left side a hydrocele was noted. The prostate was

Fig. 1—Photograph taken after formalin fixation of gross specimen. Anterior view of diverticulum and bladder. Note smooth, velvety mucosal surface of diverticulum and thinness of its wall as compared to the bladder (on left). The cavity of diverticulum was slightly less than that of the bladder. Bisected tumor mass shown to better advantage on edge at arrow.

slightly enlarged, firm, smooth, regular, and only slightly tender to palpation. Laboratory data on admission showed a straw colored cloudy urine, with pH of 5, specific gravity 1.103, albumin +++, negative sugar, 2 to 4 red blood cells per high-power field with innumerable white blood cells and bacteria. Blood chemistry and serology were normal. The white blood cell count was 11,000/cu mm with 66 neutrophils, 3 band forms, 18 lymphocytes, 6 monocytes and 7 eosinophils. The platelets were adequate and the hematocrit reading was 40%.

Kidney, ureter, bladder, and excretory urogram showed prompt appearance of contrast material. Both ureters were slightly dilated, tortuous and visualized in their entire length. The right kidney was poorly visualized. Cystoscopic examination showed 200 ml of residual urine, grossly purulent, containing mucous shreds and sediment. The interior of the urinary bladder revealed marked trabeculation. Ureteral orifices were visualized and functioned bilaterally. The bladder neck and prostatic urethra revealed anterior notching at the bladder neck. The prostatic urethra measured 1¼

Fig. 2—Anterior view of diverticulum and urinary bladder shows opened tract leading into the cavities. Mucosal lining of diverticulum is continuous with the folded mucosa of urinary bladder. Cut surfaces of tumor are shown (at arrows) remaining localized to wall of giant diverticulum.

inches in length and was somewhat irregular. Impression of trilobar benign prostatic hypertrophy was gained.

During the hospital course a transurethral resection of the prostate was performed followed by bilateral orchiectomy upon histologic diagnosis of adenocarcinoma of prostate. However, after orchiectomy he became lethargic, edematous, and developed a pleural effusion on the right. Thoracocentesis removed 700 to 800 ml of serosanguineous proteinaceous fluid. The patient died on the fifty-fifth day of hospitalization.

Autopsy findings unrelated to his basic illness included cachexia, chronic adhesive fibrous pericarditis and pleuritis, moderate myocardial hypertrophy, coronary artery sclerosis, and emphysema. The visceral pleura of the right lung was shaggy, thickened, opaque, and roughened by the presence of firm whitish nodules measuring from 0.5 to 0.6 cm in diameter and slightly elevated above the surface. The left lung was similarly involved but to a much lesser degree. Lung parnechyma contained mutiple white tumor nodules, varying in size from 0.5 to 2 cm in diameter and of firm fibrous consistency. The largest and most numerous tumor nodules were located in the right lower lobe. Many of the peripheral and medium-sized branches of the pulmonary arteries were occluded by embolic thrombi. Thrombosis was noted in the prostatic plexus of veins. The adrenals showed barely visible gross foci of coagulation necrosis, surrounded by microscopic granulomas of undetermined etiology. Liver, spleen, gastrointestinal tract and kidneys were essentially unremarkable.

Urinary bladder showed a giant diverticulum, measuring 8 to 9 cm in diameter, perched on the dome with a communicating 0.6 cm orifice (Figs 1 & 2). In the superior (dome) wall of the diverticulum, distant from and completely separate from the ostium, was a circular disc-like elevated tumor mass measuring 4 to 5 cm in diameter and 1.4 cm in thickness. The external or serosal surface was smooth except for an area of induration and thickening forming a 2-cm flat mass projecting slightly above the main serosal surface. Some of this mass consisted of lobulated adipose tissue (Fig 2). The inner aspect of the tumor presented a flat, elevated (0.9 cm) roughened and ulcerated necrotic surface speckled with small hemorrhagic foci (Fig 1). The tumor on cut surface was of firm fibrous tissue consistency, with multiple foci of hemorrhagic discoloration and necrosis. The mucosal surface of the diverticulum was smooth, of velvety texture, and pale purplish-tan in color, except in the area of the tumor. The diverticulum and urinary bladder cavities contained a small amount of cloudy reddish fluid. The entire wall of urinary bladder was thickened and the edematous mucosa of reddish-purplish color (Fig 2) was moist, thin, soft and not fixed to the wall in any area. Ureteral orifices were patent to the passage of a probe. Both ureters were slightly dilated. Prostate gland outline appeared enlarged (5 x 2.6 x 3.9 cm) but not interpreted as tumor. Urethral surface was purplish and roughened. Brain was not examined due to limitation of autopsy permit.

The histologic appearance of the tumor mass in the vesical diverticulum was that of a sarcoma characterized by a general pattern of elongated cells in poorly defined fascicles, interrupted irregularly by foci of necrosis and hemorrhage. The tumor cells

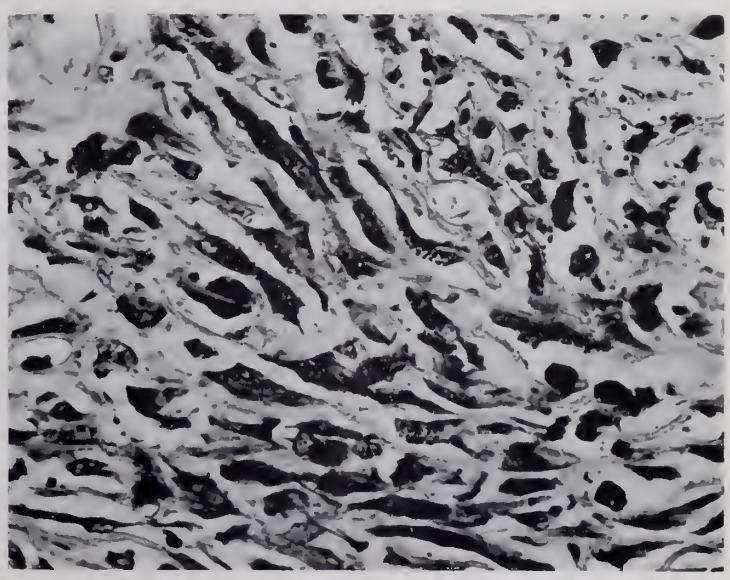


Fig. 3—High-power photomicrograph of cellular tumor shown in Figure 4. Note myoblasts and rhabdomyoblastic cells at varying stages of differentiation. Cross striations are evidence. PTAH stain.

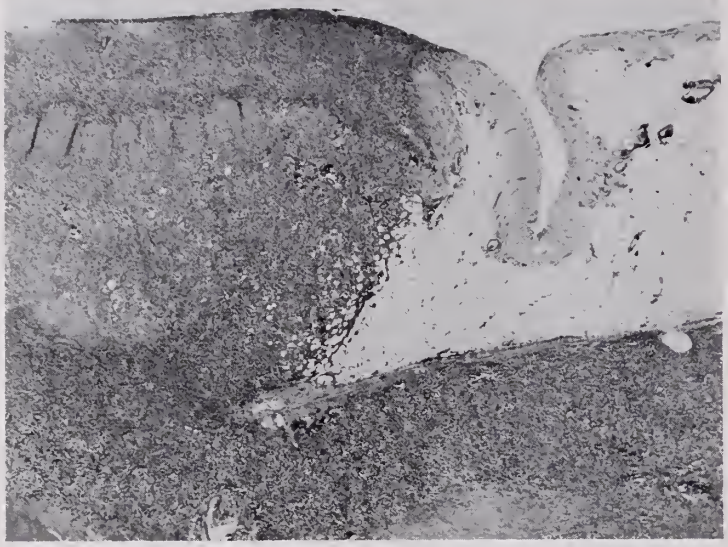
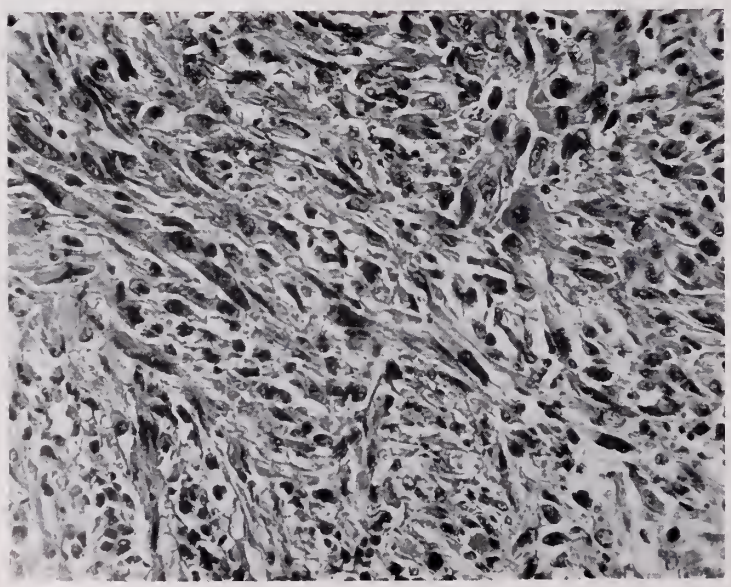


Fig. 4—Low-power photomicrograph of tumor in wall of diverticulum shows a highly cellular tumor tissue invading subserosal fat. The peritoneal cleft noted on the right delineates the external bulging edge of the circular tumor mass. Mesothelial lining is intact over the edges of the tumor and uninvolved wall of diverticulum.

were large and generally elongated but with blunt "squared" ends of cytoplasm, for which descriptive designations of "ribbon" or "strap" cells have been applied by others. The deeply eosinophilic cytoplasm presented a fine granularity in plump cells and longitudinal fibrillar appearance in the elongated forms. Phosphotungstic acid hematoxylin preparations demonstrated cross striations (Fig 3) which were only suggestive in the hematoxylin-eosin slides. Many cells were angular or plump, and multinucleation was common. Elongated cells had a tendency to contain several nuclei in a row in the long axis of the cell (tandem). Still other multinucleated cells resembled conglomerate grouping of nuclei and great variation in the size and form of the individual nuclei. Generally, nuclear membranes and irregularly clumped chromatin masses were deeply stained; and although many nuclei appeared moderately vesicular, much variation existed and many cells were deeply stained without distinct nuclear detail. Nucleoli were common and generally large. This pattern of tumor cells continued in the subperitoneal fat of the diverticulum and in all of the metastases (Figs 4 & 5). Portions of the diverticulum not involved with tumor consisted of fibrous tissue covered by an inner surface of transitional epithelium. In areas contiguous with the tumor, inflammation blended with the tumor.

Fig. 5—High-power photomicrograph of tumor nodule in lung shows elongated myoblastic cells possessing hyperchromatic blunted nuclei with significant eosinophilic cytoplasm. H&E stain.



Discussion. Sarcoma complicating a diverticulum is an extreme rarity. One therefore cannot draw statistical conclusions as to incidence, age, distribution, sex difference, and management. If the incidence of sarcomas was greater and behavior less vigorous, one would suspect a parallelism to primary carcinomas in this situation. Abeshouse and Goldstein[28] reviewed 1,009 cases and noted that 30 cases of diverticula were complicated by primary carcinoma of epithelial origin. The greatest number involved males with an average

age of 57 years. On the other hand, Kutzmann[44] did not observe a single case of carcinoma in 100 cases of vesical diverticulum studied. Nemoi et al[45] summarily concluded that the incidence of tumors in vesical diverticulum exceeds that of the urinary bladder. They advocated the removal of vesical diverticulum for the prevention of tumor development.

In the lower urinary system rhabdomyosarcoma has been known as sarcoma botryoides, embryonal rhabdomyosarcoma, myosarcoma, myxosarcoma, myxorhabdomyosarcoma, pleomorphic rhabdomyosarcoma, and polypoid rhabdomyosarcoma. All terms serve either as histologic and/or gross designation. McFarland[46] collected 119 names for such tumors, which presently are reduced to three morphologic variants: (1) botryoid or embryonal, (2) pleomorphic or adult, and (3) alveolar rhabdomyosarcoma.

Seemingly, cross striations of myoblastic tumor cells as a diagnostic criterion of rhabdomyosarcoma linked or implied origin from striated muscle. Findings of morphologic variants of this tumor in vesical neck, trigone area, urinary bladder wall, and prostate led to varied interpretations of histogenesis. One does understandably conclude that such tumor arising in zones of smooth muscle would evoke diversity of opinion. Hunt[9] believed that it arose from "wandering or vagrant myoblasts," thus emphasizing heterotopic displacement of rhabdomyoblasts from sites where they are normally present, urogenital diaphragm, external urethral sphincter, prostatic capsule, and abdominal wall. Stout,[47] however, placed the embryonic form in the group of malignant mesenchymoma. His analysis[48] of 121 cases also led to the description of pleomorphic rhabdomyosarcoma. McFarland[46] emphasized its origin from undifferentiated mesenchyme of urogenital ridge; Willis[49] suggests undifferentiated young tissue; Mostofi and Morse[15] preferred the term "multipotential embryonic tissue;" Patton et al[50] compared the features of rhabdomyosarcoma to developing skeletal muscle in the fetus and embryo. The preceding older literature emphasized origin of rhabdomyosarcoma from embryonal cell rests or residua along the course of Wolffian and Müllerian ducts. This led to the concept of dysontogenetic tumors. Theories of transformation or metaplasia of smooth muscle to striated variety have not received enthusiastic support. Carey's[51, 52] experiments in dogs suggesting transformation of smooth muscle fibers of urinary bladder to striated type, when subjected to extra tension, have not been confirmed and are subject to other interpretations. The literature has been reviewed by Legier[13] and Batsakis,[53] who support the conclusion of "nonspecific mesenchyme incorporated in the developing adult structures with the mesonephric duct."

It is generally agreed that microscopically rhabdomyoblastic cells present either as plump round forms, strap-shaped cells, racquet-shaped cells, or multinucleated forms. The cytoplasm is distinctly eosinophilic and granular or fibrillar. The number of cells possessing transverse striations varies greatly. An admixture of cell types is usually present depending upon the degree of differentiation. The alveolar form shows predominantly round forms in clusters or pseudoglandular pattern, while the adult pleomorphic form presents myoblastic cells with transverse striations in addition to multinucleation and pleomorphism. The botryoid or embryonal form, most frequently encountered in urogenital regions, has been grossly described as polypoid, gelatinous, grape-like masses (meaning botryoid), soft or firm, and frequently protruding into the bladder cavity. The stroma is edematous or myxomatous, raising the question of tumor cell degeneration. The cells are loose or widely apart.

Our case showed a firm dense cellular mass of fibrous tissue consistency, disc-shaped and white to gray on cut surface except for foci of hemorrhagic necrosis. Histologically, it fits the criteria of adult or pleomorphic type of rhabdomyosarcoma. The majority of reported cases as previously stated involved the urinary bladder, mainly at the base. In our case it was only in the wall of the diverticulum with metastatic sites in lungs, pleura and diaphragm. Rhabdomyosarcoma have a very poor prognosis, because they spread by continuity and permeate lymphatics and blood stream. Commonly presenting symptom is gross hematuria, but in most cases it is a late manifestation of the disease.

Summary. A case of primary rhabdomyosarcoma developing in a giant vesical diverticulum in a 74-year old man is presented. Metastases were present in lungs, pleura, and diaphragm. Pertinent literature on pri-

mary neoplasm (carcinoma and sarcoma) complicating urinary bladder diverticulum and on rhabdomyosarcoma of the urogenital region is cited.

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Surgical Parameters in Idiopathic Ulcerative Colitis

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■ SINCE THE FIRST pathological description of ulcerative colitis by Wilkes and Moxon[1] in 1875, our understanding of the clinicopathological and therapeutic concepts in relation to ulcerative colitis has become sufficiently standardized to permit certain broad generalizations.

Idiopathic ulcerative colitis may be defined as a nonspecific inflammation of the colon accompanied by varying degrees of ulceration. Though the descending and sigmoid colon suffer the maximal intensity of the inflammatory process, it often spreads back as far as the ileocecal valve at which site ulceration ceases abruptly, unless incompetence of the ileocecal valve mechanism results in a secondary ileitis due to "backwash" of infected material.[2]

To compound the problems of pathogenesis, the colon may suffer ulceration due to primary disease of the ileum. This ileocolitis may manifest as a right-sided or segmental colitis. The presence of a macrocytic anemia and steatorrhea will suggest the ileal involvement, which may be demonstrable on careful radiological study. Colonic involvement may extend to involve the whole large intestine, making the differentiation from idiopathic ulcerative colitis even more difficult.

At the other limit of the clinical spectrum are the occasional cases of localized proctocolitis. Here the disease may be mild, with long remissions but with gradual extension of the disease process proximally until the development of a full blown case of ulcerative colitis.

Toxic Megacolon. This refers to a phase of idiopathic ulcerative colitis in which an acute progressive distention of the right colon develops in the absence of mechanical obstruction. This colonic dilatation extends from the splenic flexure to the cecum, but does not involve the lower descending colon. Although severe diarrhea persists, this condition is associated with diminished peristaltic sounds on abdominal auscultation. Steroid therapy does not exert any great effect on this aspect of the disease, and in fact, this complication is known to occur in patients on longstanding steroid therapy. It is considered that colonic infection with pericolitis causes a disturbance in colonic motility as well as explaining the abdominal pain, fever, and leukocytosis that is associated with it.

The possibility that injury or destruction of ganglionic cells within the intestinal wall is a causal factor in the pathogenesis of toxic megacolon has been considered but never confirmed by study of the resected specimens and is further refuted by the fact that spontaneous remissions do occasionally occur.[3]

Surgical Pathology. Without attempting to review the many etiological considerations such as possible relationship to bacillary dysentery, to Bargen's streptococcus, lysozyme, allergic, vascular, psychosomatic and dietetic factors, it is important to emphasize that idiopathic ulcerative colitis is a disease in which an adequate medical regimen is of paramount importance with emphasis on appropriate hydration, vitamin supplementation, the use of insoluble sulfonamides and antibiotics and steroids, both systemically and topically. It is equally important to appreciate at what point and for what reasons surgical intervention becomes necessary, and this presupposes an understanding of the pathological sequelae of this disease.

The earliest discernible colonic changes can be viewed at sigmoidoscopic examination, and it will be seen that hyperemia and edema become obvious at an early stage of the disease to be followed by thickening of the mucous membrane which bleeds very readily. At a later stage small abscesses form in the mucosa and rupture with the formation of small yellow ulcers.

Examination of a colectomy specimen from a severe case of ulcerative colitis shows the colon to be contracted both in length and

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diameter. The wall becomes thickened and rigid with loss of normal elasticity.

The deep red, hemorrhagic mucosa is frequently interspersed with ulcers which run longitudinally being separated by ridges of surviving mucosa. Extension of the ulcers through the submucosa to the muscle coat with ensuing muscle spasm will go on to the subsequent fibrotic scarring which will produce strictured areas. The mucosa at the margin of the ulcers becomes undermined and loose in its attachment and becomes polypoid mucosal tags. These are found in about 10 per cent of longstanding cases and will develop into rounded pedunculated pseudopolypi composed of mucous membrane and a granulation tissue core which gradually becomes fibrotic. Cancer of the colon is found in 3 to 5 per cent of patients with inflammatory pseudopolypi, and the possibility of malignant change provides an extra hazard in the longstanding case; but it is important to appreciate that 15 years is the average period of time which elapses between the first symptom of polyposis and the detection of intestinal cancer. It may thus be said that any patient in whom severe ulcerative colitis has lasted more than 10 years is entering a phase of life when intestinal cancer becomes a definite risk.[4]

Clinical Picture. Although ulcerative colitis may have an insidious onset, it is more usually acute with severe debilitating diarrhea. The stools contain pus, blood, and mucus and a high proportion of eosinophilic cells. There is a profound loss of weight, of vitality and strength, and a marked secondary anemia, fever, leukocytosis, tachycardia, and a raised sedimentation rate.

Characteristic of the disease are periods of spontaneous remission and quiescence which may endure for several years.

Complications. Depending on the severity of the colonic disease process, it may become complicated by abscesses and fistulae which may be pericolic, perirectal, ischiorectal or perianal, while in the female rectal-vaginal fistulae may develop. Severe hemorrhage may endanger life while stricture formation, though not common, may be a cause of obstruction. Perforation of the weakened spot along the often paper-thin colon may occur though less frequently than might be anticipated. Toxic megacolon is a serious complication being associated with high fever and serious threat to the patient's life. The development of pseudopolypi may further aggravate symptoms while the development of carcinoma may further be a source of great danger to the patient.

Systemic complications may occur and of these the most significant are pyoderma gangrenosa, arthritis, often mono-articular affecting the larger joints, iritis, and erythema nodosum.

Diagnosis. (1) *Bacterial examination of stools:* In this regard it is most important to exclude specific forms of colitis. Example: bacillary or amebic dysentery. The possibility of uremic colitis should always lead to examination of the urinary tract and estimation of the blood urea.

(2) *Proctoscopy and sigmoidoscopy:* It is important to avoid anesthesia in these patients, nor should air inflation be implemented because of the great risk of perforating a weakened area of the colon. Apart from the classical mucosal appearance described earlier, this examination affords an opportunity for biopsy of pseudopolypi, and other pathological areas for histological study.

(3) *Radiological examination:* The pipestem, smooth, narrowed left colon provides a classical appearance on barium enema, while in the later stages the presence of pseudopolypi will demonstrate the appropriate filling defects. In the acute stage, the marked intestinal irritability will often prohibit a barium enema while a plain x-ray film of the abdomen will demonstrate the marked colonic distention of toxic megacolon, and it is equally unwise to utilize barium enema in these cases for fear of precipitating perforation.

Indications for Surgery. The decision for an operation in a case of idiopathic ulcerative colitis is made on clinical grounds and attempts should always first be made to obtain a remission by medical means. Where surgery is definitely indicated, it is important to spend a period of time in building up the patient's status to an optimal degree. This will require restoration of blood volume with blood transfusion, replenishment of fluids and electrolytes, as well as the need to reduce toxemia from secondary infection, with the drug of choice generally being chloramphenicol.

Specific Indications for Surgery. (1) Steady deterioration despite medical treatment. (2)

Chronic cases severely disabled by their recurrent diarrhea but which remained refractory to medical treatment. (3) Acute emergencies including acute fulminating disease, hemorrhage, perforation, and peritonitis. (4) Toxic megacolon. (5) The occurrence of complications such as fissure-in-ano, fistulae, rectal strictures as well as the systemic complications such as pyoderma gangrenosa, arthritis, iritis, and erythema nodosum. (6) The presence of carcinoma of the colon.

Type of Surgery. There is little doubt that in planning the surgical strategy for the control of idiopathic ulcerative colitis, there has been a shift in emphasis from purely diversional surgery to primary excisional surgery. This has resulted from the realization that there is an undoubted predisposition to carcinomatous change in the diseased intestine, while ileostomy alone in many cases fails to halt the progress of the disease as the septic paper-thin colon continues to provide a source of toxemia.

(1) *Ileostomy plus colectomy:* A long left paramedian incision extending from the pubis to the costal margin provides excellent access to the colon including the difficult splenic flexure. The colectomy can be completed by dividing the rectum low down in the pelvis with suture of the rectal stump below the pelvic peritoneum. This has the advantage of permitting a subsequent simple perineal resection of the rectal stump. This technique may in some cases be associated with sepsis, and in such a case it may be wiser to transect the colon at the terminal sigmoid area which is then exteriorized as a suprapubic colostomy at the lower end of the main wound.

(2) *Ileostomy plus proctocolectomy:* If the patient's general condition permits, one may mobilize the entire rectum and complemented by a perineal dissection complete one-stage proctocolectomy.

(3) *Colectomy plus ileorectal anastamosis:* Though an esthetically desirable objective, ileorectal anastamosis is suitable for only a small proportion of patients requiring surgical treatment for ulcerative colitis who are fortunate to have a completely uninvolved rectum. Even then, subsequent proctitis may flare up and lead to septic complications or be responsible for the ultimate development of rectal carcinoma with the need for removal of the rectal stump and establishment of an ileostomy.

The Ileostomy. It is important to take great care in fashioning the ileostomy, and careful attention should be paid to the following:

(1) *Technical consideration:* The ileostomy should not be placed in the line of a main wound scar, but should be placed after removal of a disk of skin and division of the anterior and posterior rectus sheaths across the lines of their fibers to prevent intestinal constriction at the point half way along the line from the anterior superior iliac spine to the umbilicus. The ileum should be made to project 1½ inches beyond the abdominal wall skin, while fixation sutures between the ileal mesentery and the anterior peritoneum should not only close the lateral space and prevent subsequent intestinal obstruction, but should also reduce the incidence of prolapse of the ileostomy. Immediate eversion of the terminal ileum and mucocutaneous suture will secure immediate epithelial apposition and prevent later stenosis of the ileostomy.

(2) *After care:* Ileostomy management is greatly facilitated by a well-fitting bag as well as by appropriate mental orientation of the patient. To those who would deplore the relatively unesthetic surgical strategy for this condition, I would quote a little verse from Hilaire Belloc who in describing the sad story of Henry King said:

> "Physicians of the utmost fame
> Were called at once, but when they came
> They answered—as they took their fees
> There is no other cure for this disease."

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AMERICANS will buy about $60 million worth of appetite control drugs this year.

* * *

AS OF APRIL 1965, the Food and Drug Administration, Bureau of Medicine—which supervises the drug industry—employed 96 physicians 23 veterinarians, 61 chemists and food and drug officers, 12 other professionals, and 155 clerks and caretakers. The bureau hopes to add 268 employees this fiscal year.

CASE REPORT

Parotidectomy for Chronic Parotitis

By JAMES K. THEISEN, M. D.
Green Bay, Wisconsin

■ EXCISION OF THE parotid gland with preservation of the facial nerve and usually without excision of the small deep lobe has been accepted generally as the procedure of choice in removal of benign tumors of the parotid gland. The preference for parotidectomy rather than enucleation is based upon the lower incidence of recurrence of the tumor after parotidectomy and the lessening of the probability of injury to the facial nerve. The latter is supported by the much higher incidence of permanent paralysis of the facial nerve after secondary operations for recurrence of mixed tumors.

On the other hand, excision has been gaining support more slowly in treatment of chronic parotitis, largely because of fear of injury to the facial nerve. Gerry and Seigman[1] as recently as 1955 stated that excision of the parotid gland was not generally feasible in the management of chronic parotid sialadenitis.

Beahrs, Devine, and Woolner[2] and Keenan, Beahrs, and Devine[3] have indicated the frequent ineffectiveness of conservative measures in the treatment of chronic parotitis. These measures have included massage, vaccines, antibiotics, x-ray therapy, compresses, and dilatation of the parotid duct.

Perzik[4] reported that temporary facial paresis was present in all of his cases in which the facial nerve was exposed and that it was of "wider extent and persisted longer than that noted in comparable surgery for neoplasms." This is probably due to the presence of inflammatory reaction and adherence of the perineural tissues and makes an exceptionally careful dissection of the nerves important. It has been my preference to initially identify and dissect the peripheral branches of the facial nerve with eventual exposure of the entire nerve on removal of the gland rather than to expose the main trunk of the nerve initially. No instance of permanent paralysis of the nerve has been encountered in cases of benign tumors.

The case presented here is that of a child with chronic parotitis associated with recurrent swelling and marked by necrosis as a prominent pathologic feature, the clinical course being initiated by trauma. The child was effectively treated by parotidectomy.

CASE REPORT. A 4-year-old girl was struck in the left cheek by a rock on July 3, 1961. There was immediate swelling which gradually subsided, but subsequently recurred intermittently. Further history was essentially noncontributory. Examination three months after the injury revealed a firm, 3×3-cm swelling of the left preauricular area which gradually tapered off to the periphery and which extended up to the zygomatic process of the temporal bone. There was hemorrhagic discoloration of the skin over the mass, which was not movable. There was no facial weakness, or intrapharyngeal swelling, and no lymphadenopathy. Further general physical examination revealed nothing unusual.

Two days later a biopsy was carried out. On incising the parotid gland there was found a normal appearing gland to a depth of 3 mm. Below this was a mucoid degeneration. Probing revealed a cystic degeneration throughout the gland. Microscopic examination revealed a chronic granulomatous inflammation, foreign-body type. A month and a half later a hematoma, which resulted from trauma a week before, was evacuated. Because of persistence of the swelling the patient was readmitted to the hospital and a total superficial parotid lobectomy was per-

Fig. 1—Preoperative appearance.

Fig. 2—Operative field after removal of the parotid gland. The five branches of the facial nerve are intact.

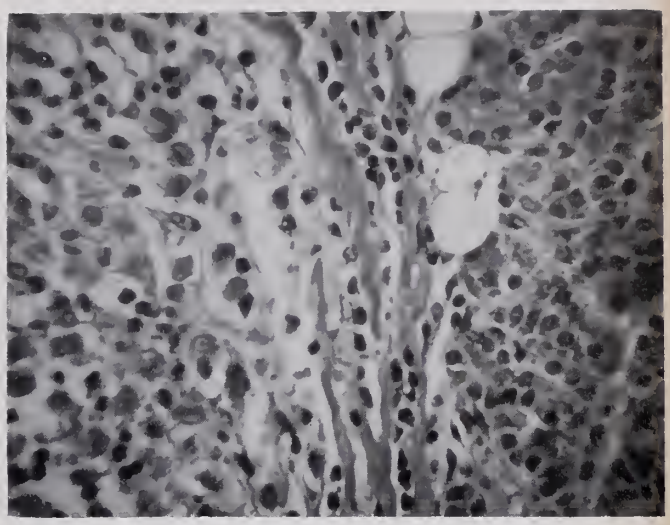

Fig. 3—Normal peripheral rim of parotid gland at the right and necratic gland at the left (x430).

formed (Fig 1). Inflammatory reaction extended beneath the zygomatic arch. The degenerated portions of the gland revealed gross evidence of chronic inflammation and necrosis. There was extensive periglandular fibrosis. Care was taken to preserve the facial nerve and its branches (Fig 2).

Microscopic examination revealed extensive degeneration with numerous inflammatory and phagocytic cells present (Fig 3).

The postoperative course was uneventful except for a temporary partial facial paralysis which persisted for six weeks. A very slight weakness of retraction of the lower lip has remained (Fig 4).

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Fig. 4—Appearance 15 months after operation.

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THE WONDERFUL WORLD OF DRUG SERENDIPITY

Serendipity has always provided some of the greatest discoveries. Search for a seasickness remedy produced the antihistamines. Investigation of a hiccough remedy yielded a potent analgesic. Subsequently, the antihistamines were discovered to be antinauseants; then tranquilizers. Snake venoms, studied for the treatment of arthritis, were found to be anticoagulants and fungicides. The combined study of antibacterial drugs and cabbage feeding led to the antithyroid drugs. From these, it can be seen that the ultimate destiny of a new drug is not always predictable until its use is widespread. A. LEE LIGHTMAN, M.D., in *Experimental Medicine and Surgery*, 22:2–3, (Jun-Sep.) 1964.

Surgical GRAND ROUNDS NO. 1 OF A SERIES

UNIVERSITY OF WISCONSIN MEDICAL CENTER

EDITOR'S NOTE: *Surgical Grand Rounds are conducted weekly as a portion of the University of Wisconsin Medical Center program in surgical education. This conference is held at 4 PM on Wednesdays in Room 300, University Hospitals, and guest physician participation is invited. Cases presented at the Grand Rounds will be published in a selective manner periodically in the* WISCONSIN MEDICAL JOURNAL. *Two cases have been chosen for review on this occasion: regional enteritis and gastrojejunocolic fistula. Dr. Robert C. Hickey, professor and chairman of the Department of Surgery at the UW Medical Center, and Dr. Walter D. Schwindt, fellow in surgery, are collaborating in presenting these Grand Rounds to the* JOURNAL *as a cooperative effort in furthering the postgraduate teaching program of the State Medical Society's Commission on Scientific Medicine.*

REGIONAL ENTERITIS

Case Presentation.* *Dr. Louis Bernhardt:* This 40-year-old white man was admitted to the hospital with epigastric and left lower abdominal pain. Ten months previously a gastric ulcer was diagnosed and healed on medical management; however, his symptoms now are similar to those previously experienced. Three years ago a duodenal bulb deformity was seen on an upper gastrointestinal series. He complained also of intermittent episodes of loose, watery diarrhea but denied blood in the stool. He has lost approximately 40 lb since the previous examination.

Physical examination revealed a somewhat pale white man with evidence of recent weight loss and tenderness to palpation in the epigastrium. The hematocrit reading on admission was 40.5% with a leukocyte count of 19,000/cm. There was no occult blood in the stool. Other routine studies were unremarkable. Shortly after admission, the epigastric pain increased and he had several vomiting episodes. A nasogastric tube was placed and blood-stained gastric content aspirated. Subsequently, his hematocrit reading fell to 34.5%; however, following a blood transfusion, his condition stabilized and the upper gastrointestinal bleeding ceased. His gastric aspirate continued in excess of 1,500 ml per day.

After his condition stabilized, surgery was performed and no evidence of a gastric or duodenal ulcer was seen. There were, however, two areas, typical on gross examination, of regional enteritis in the proximal and distal ileum. The small intestine was obstructed and dilated proximal to the first of these lesions. There was induration of the intestinal wall and evidence of acute and chronic inflammation. The proximal lesion was resected along with 70 cm of small intestine and an end-to-end anastomosis performed. The distal lesion, though lesser in extent, was adherent to the sigmoid colon, and its removal would seem to hazard entry into the colon. For this reason, a side-to-side ileotransverse bypass colostomy was established. The postoperative course was uneventful.

Discussion. *Doctor Bernhardt:* Regional enteritis is characterized by an acute or chronic necrotizing and cicatrizing inflammation.[1] No medical treatment including steroids is definitive. Conservative treatment deserves a trial prior to surgical intervention, since the recurrence rate following surgery is high. This disease afflicts young adults and is believed to be more common among the Jewish people. Less than 10% of the patients have onset of symptoms after the age of 50 years, and 60% of the patients have onset of symptoms between the ages of 10 and 35.[2] The main symptoms are abdominal pain, diarrhea, anal fistulae and fissures, and a right lower quadrant mass. Unlike ulcerative colitis, gross rectal bleeding in regional enteritis is rare, although abdominal pain and diarrhea are frequent.[3] One may find associated clinical features such as steatorrhea, avitaminosis, hypocalcemia, arthritis, digital clubbing, erythema nodosum, as well as abdominal and perineal abscesses.

X-ray examinations of the gastrointestinal tract, particularly by barium meal, are diagnostic in 95% of the cases. The x-ray

* From Madison Veterans Administration Hospital.

findings are those of stricture or obstruction of the terminal ileum and, with the "string sign," often noted are internal fistulae, cecal defects, obstruction of the jejunum, and increased bowel motility. In 85 patients from the Lahey Clinic reported by Colcock, 34% of the patients had associated gastrointestinal disease such as cholelithiasis (10%), ulcerative colitis (8.2%), and duodenal ulcer (8.2%).[3] Other entities which may be found concomitantly with regional enteritis are: gastric ulcer, multiple polyposis, leiomyomata of the cecum and small intestine, diverticulosis of the small intestine, and rectal polyps.

The disease involved the terminal ileum in upwards of 90% of the patients, and the cecum was involved in approximately 10%. There are skip areas in about 18% of the patients in the proximal ileum, the jejunum, the stomach, and the esophagus, as well as the rectum. The disease begins in the submucosa of the intestinal wall, and the granulomatous processes in the mesentery are usually secondary to the former.[4] Some pathologists feel that the origin is in the lymphatic and therefore many surgeons widely resect the involved mesentery nodes. In the acute form the intestinal wall is hyperemic, edematous and thickened, with the serosa usually covered by a fibrous exudate. This occurs in the terminal ileum and most frequently stops abruptly at the ileocecal valve, although in 5% an associated ileocolitis is present.[2] The chronic form demonstrates intestinal and mesenteric thickening with cicatricial obstruction as well as enterocolic fistulae and abscesses. Unlike ulcerative colitis, regional enteritis does not seem to spread by direct extension except as it may involve the adjacent cecum.

What, then, is the proper medical treatment and what are the indications for surgery?

The medical treatment consists of dietary restriction, stool bulk-forming preparation, vitamin supplements, enteric antibiotics, appropriate rest and removal of stress situations from the environment and, lastly and most controversially, steroids. Although steroids certainly are beneficial in the medical management, many surgeons feel that preoperative use of steroids increases the technical hazards of operation in regional enteritis as it does in ulcerative colitis.

What are the indications for surgery? Medical management should be undertaken initially, since definitive surgery has a recurrence rate upwards of 30 to 35%.[3] In the recent series from the Lahey Clinic, 47% of the patients operated upon had small-bowel obstruction.[5] Other indications are severe diarrhea, an abdominal mass, severe abdominal pain, enterocutaneous fistulae, intestinal perforation, bladder fistulae, weight loss, and bleeding. Many of the above come under the heading of progressive symptomatic terminal enteritis, and this category along with obstruction are the main indications for definitive surgery.

Progressive or recurrent enteritis in the postoperative period may be an indication for re-exploration. Adequate surgical treatment consists of resection of the involved areas.[6] The skip areas are removed if causing obstruction, otherwise they are often left in place. If two areas are extensively involved with an intervening 3 feet of normal intestine, one should perform two resections leaving as much normal intestine as possible. A much better chance for cure without recurrence is obtained if the ulcerated, infected intestine (often associated with small mesenteric abscesses) is removed, rather than merely bypassed, since bypassed areas may require resection within five years; in the Mayo Clinic series 16% of 250 patients required reoperation.[6]

Histological examination at the suture line is unnecessary if one removes 3 to 4 inches of grossly normal intestine proximal to the involved areas.[5] The recurrence is usually proximal to the anastomosis or progression of the skip areas. Very rarely is the disease distal to the ileocolic anastomosis. One should always avoid leaving the diseased intestine and certainly avoid stenosis at the suture line which could cause stasis and an exacerbation of the disease. Anal fistulae and fissures will heal spontaneously when the regional enteritis is medically or surgically corrected. The lesions in the upper gastrointestinal tract may heal with greater propensity, and therefore surgical intervention is often not necessary.[2]

Regional enteritis is a chronic disease with remission and exacerbations. During acute exacerbations, signs and symptoms suggestive of acute appendicitis may appear and the surgeon will be forced to explore the abdomen if the appendix is still present.

Appendectomy in the face of regional enteritis is still a controversial subject. Ferguson suggested in 1957 that the appendix not be removed if the cecum appears normal. Perhaps, if the cecum and base of the appendix appear normal, an elective appendectomy should be performed, and the amputated appendoceal stump will heal.[7,8] If incidental appendectomy with a normal cecum and appendix leads to postoperative fistulae, it may be due to handling of contaminated bowel rather than the incidental appendectomy.[9]

Since 25% of the patients develop an enterocutaneous fistula following appendectomy, one should not perform an appendectomy if there is involvement of the cecal wall, especially if the disease is in the acute state.[5,8,9] One can usually remove the appendix safely if the cecum is not involved or if the disease is in a fibrotic or cicatricial phase. If an appendectomy is performed, the hazard of making a diagnosis in acute exacerbation of recurrent regional enteritis in a patient with acute appendicitis is avoided. Once an enterocutaneous fistula develops, it will usually persist until the diseased area is removed. The complications of surgical treatment of regional enteritis include enterocutaneous fistula and abdominal abscesses. Therefore the anastomosis should be well constructed without stenosis and the definitive procedure of choice should be resection in most cases.

Dr. Robert C. Hickey: Regional enteritis is a fascinating entity. The names that have been applied to this condition offer some hints. The term cicatrizing enteritis, regional ileitis, regional enteritis, and Crohn's disease are applicable, the latter in recognition of the first clear description by Doctor Crohn 35 years ago. The classic description is that of a thickened mesentery with enlarged fleshy lymph nodes and a stiff-thickened hyperemic bowel. The serosal surface is dull and frequently covered with grayish exudates—particularly early in the disease.

The cicatrization results as a consequence of the edema being followed by fibrosis. There is ulceration of the mucosal surface and microscopically the inflammatory process involves the entire thickness of the wall. This is in contrast to ulcerative colitis, where the lesion is predominately a mucosa ulceration while the serosa may be within normal range. Fibrosis and shortening of the intestine is an end state.

I wonder about this patient. Isn't he a bit unusual with respect to age? He looks to be about 60.

Doctor Bernhardt: The patient was 40 years of age. The elderly appearance undoubtedly was associated with the cachexia.

Doctor Hickey: With respect to age, this is characteristically a disease of young adults but does occur in the age extremes. As a matter of fact, the most famous patient with regional enteritis was 65 years of age and had his illness cared for by Gen. Leonard B. Heaton, Dr. Isadore S. Ravdin, Col. T. J. Whelan, and Dr. Brian Blades. The illness of President Eisenhower, who was 65 years of age at the time, has been documented recently in the ANNALS OF SURGERY.[10] As you will recall, the President was treated by a bypass procedure—that is, an ileocolostomy, and the course was uncomplicated. I am told that criticisms were directed toward this bypass procedure. While perhaps this is inferior to an extirpation from a strict point of view, it was a very obvious choice in such an important patient.

Question: Was not President Eisenhower's problem primarily one of obstruction?

Doctor Hickey: This is a very important point. President Eisenhower's disease had reached the cicatrizing late stage and he was being operated upon for an obstruction, an emergency. Further, he had had a recent myocardial infarction. The most conservative procedure appeared to be the one carried out. The problem was predominately one of obstruction and thus this was the obvious choice. One further thought—there may be recurrences of the disease and with repeated resections the surgeon (and the patient) will run "out of goods."

It might be of interest to hear about another patient who has just recently been admitted to the University Hospitals, a young girl, age 21, more in keeping with the proper age group. This girl has a series of complications typical of regional enteritis.

William Lundberg (Med IV): Recently a 21-year-old markedly cachetic and apprehensive woman was admitted to the hospital on an emergency basis with the referral diagnosis of regional enteritis complicated

by an enterocutaneous fecal fistula and peritonitis. She had had four surgical procedures in a span of three months.

Three months prior to this hospital admission the patient had symptoms and signs of appendicitis and surgery was performed. At the time of surgery regional enteritis was diagnosed and the terminal ileum, cecum, and appendix were resected. Several weeks later she underwent surgery for obstruction. Then, three weeks prior to her admission here, she had surgery for intestinal perforation followed in two weeks by a second perforation and surgical closure. Upon redevelopment of a fecal fistula and peritonitis, she was referred here.

Her complications were further compounded by a rectal fissure and a presumptive duodenal ulcer. She is bleeding at the present time, either from a duodenal ulcer, a so-called stress ulcer, or from an area of regional enteritis. In summary, her complications have included: marked cachexia, possible duodenal ulcer, enterocutaneous fecal fistula, obstruction, perforation, peritonitis, rectal fissure, and bleeding. Her initial difficulty was preceded by signs of appendicitis.

Dr. John Benfield: My experience with the differential diagnosis between acute exacerbation of regional enteritis and acute appendicitis centers around two patients whom I recall vividly. One patient at the University of Chicago was admitted with the diagnosis of acute appendicitis and my hand was stayed by the wiser judgment of Doctor Prohaska and Doctor Palmer. The patient was treated conservatively with steroids and other supportive measures and did well. At a time of election, some three weeks later, the terminal ileum with regional enteritis was removed.

Recently we have had a patient admitted where the diagnosis was initially unclear. The predominant problem on admission of this 40-year-old woman was that of recurrent abscesses in the pelvis from a site of origin which initially was unknown and drained from the vagina. X-ray studies and subsequent laparotomy revealed regional ileitis as the source of fistula. Following resection the patient continues to do well.

Dr. Kenneth Lemmer: I have three comments on regional ileitis and they focus around the thoughts of (1) operation for appendicitis, (2) the severity or significance of ileocolitis, (3) the use of steroids.

In the acute phase, this inflammatory granulomatous condition may be mistaken for appendicitis and the initial operation is usually one for removal of the appendix. The likelihood of a fecal fistula following this is great, especially if the cecum is involved. Appendiceal fistulae have been reported in 25 to 60% of such cases. Many will argue that if the cecum is uninvolved, it is safe to remove the appendix. However, our usual plan of management in the unobstructed case is to do nothing but close to allow the acute process to subside. In many patients no further treatment will be necessary. However, if obstruction, fecal fistula, or localized abscess occurs, then secondary surgery will be necessary. Resective surgery is used in all except the burned out cases where bypass in continuity may be the treatment of choice, particularly in the elderly or debilitated patients.

When one has a combination of ileocolitis rather than just regional enteritis or ulcerative colitis, both the morbidity and mortality are increased. In a recent study reported by the Lahey Clinic, a five-year mortality rate of 49% was reported in this series of cases. This is the type of patient that may skip areas and is most likely to have recurrences.

The use of steroids in regional enteritis is controversial. It is doubtful if it is curative, but it may cause a regression of symptoms so that definitive treatment with surgical excision can be done. However, the likelihood of perforation and abscess formation seems to be increased in those patients receiving steroids.

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GASTROJEJUNOCOLIC FISTULA

Case Presentation.* *Dr. Walter Schwindt:* This 51-year-old white man was admitted to the hospital with diarrhea of five months duration. His present illness began when the patient awakened one night with diarrhea which was watery without blood or mucus. He has been having 8 to 10 bowel movements per day with little change in his diarrhea on a day-to-day basis. There have been no other gastrointestinal complaints except for a fetid odor of the breath and occasional postprandial nausea. During his present illness, he has lost 15 lb.

Nine years ago he had had a perforated duodenal ulcer closed, and eight years ago a vagotomy and a posterior gastroenterostomy were performed for chronic duodenal ulcer disease, in another hospital.

In 1961, he was admitted to this hospital with upper gastrointestinal complaints suspicious of a marginal ulcer. He received antacids and became asymptomatic. Again, in 1961, he was admitted for ulcer-like symptoms; however, no marginal ulcer could be seen on x-ray studies although gastric analysis showed considerable free acid. Physical examination on this admission was unremarkable other than for some evidence of weight loss and mild pretibial pitting edema. The patient's routine hematology, electrolytes, and urinalysis were within normal limits. However, the total serum protein was 4.6 gm/100 ml with an albumin of 2.75 gm/100 ml.

The diagnosis of a gastrojejunocolic fistula was suspected clinically, and a barium enema showed the contrast material to flow directly from the mid-transverse colon into the stomach (Fig 1). An upper gastrointestinal series was not performed at this time, since there was some fear of possible impaction within the right colon. After preoperative preparation including transfusions, the patient underwent surgery at which time the gastrojejunocolic fistula was

Fig. 1—The barium enema demonstrating the contrast material passing into the stomach via the fistula.

Fig. 2—The resected specimen with the unopened stomach superiorly and the interposed jejunum.

* From Madison Veterans Administration Hospital.

readily identified (Fig 2). The fistula with a section of jejunum and colon was excised and also vagotomy and a 50% gastric resection was performed. A gastroduodenostomy was created to restore intestinal continuity. Postoperatively, this patient has done well without diarrhea and has had a progressive weight gain.

Discussion. *Dr. Charles Yale:* This patient with a gastrojejunocolic fistula presents one of the late complications of surgical treatment for duodenal ulcer. Although there are other causes of these fistulae such as carcinoma, usually of the stomach, and ulcerative colitis, we will concern our discussion today only with the types secondary to peptic ulcer disease. These patients have almost exclusively had a posterior gastroenterostomy as a single surgical procedure or in combination with a vagotomy.

The incidence of this type of fistula among patients with a marginal ulcer is reported to be from 8.7 to 22.4%. Invariably, the presenting complaint is that of diarrhea which is persistent and without change in character on a day-to-day basis. In addition, this is almost always of an abrupt onset. The weight loss is the second most common complaint and is about as frequent as diarrhea. Other symptoms such as fecal belching, fecal vomiting, and pain are fairly common, but not of the same frequency as diarrhea.

The single most important diagnostic aid is the barium enema, since in a reported series the fistula has been demonstrated 100% of the time. With an upper gastrointestinal series the positive yield is much lower. This is probably due to the pressure differentials within the gastrointestinal tract. Earlier surgical procedures used in the treatment of this problem were multi-stage with the first stage being a colostomy proximal to the fistula. With the multi-stage procedure, the mortality rate was in the neighborhood of 5%, as contrasted to the earlier one-stage procedures, where the mortality rate was from 12% to 30%.

Barber and Madden[1] reviewed this problem in 1947 and concluded that the mortality rate was related to the severe malnourishment and poor general condition of the patient, lack of an adequate period of preoperative preparation, the technical difficulties of the procedure, and the high incidence of peritonitis secondary to the spillage of colonic content.

With the generalized improvement of surgical care, the one-stage operation has again come into favor and several large reported series, particularly the one from the Mayo Clinic,[2] report a mortality rate in the range of 3%. This patient had a portion of jejunum and colon resected. However, in the majority of patients it is not necessary to resect these portions of intestine, particularly the large intestine. Since the patient's basic problem is a recurrence of his peptic ulcer disease, additional therapy at the time of the surgery should be directed toward this problem as was in this case with the vagotomy and partial gastrectomy.

Dr. Robert Donaldson: There is evidence to show that these patients may well have their diarrhea on the basis of a massive bacterial contamination of the small intestine, such as that found in the blind loop syndrome. With the pressure differentials between the stomach and colon, there is probably not a sufficient amount of food passing directly into the colon to account for the diarrhea or one would certainly find a much higher percentage of these fistulas being demonstrated on an upper gastrointestinal x-ray series.

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* * *

WANTED: LESS HASTE IN LAWMAKING

Although there may be a need for controlling false claims for medical devices, one might well hope that the haste which resulted in the new laws and regulations about drugs will not serve as a pattern for legislation related to physical devices. The drug controls, in many respects, appear to go far beyond what is necessary to ensure reasonable safety. Surely, in the final drafting of bills on medical devices, experts in the industry as well as university researchers should be given full opportunity to make available their knowledge and experience.—MORRIS FISHBEIN, M.D., in *Medical World News*, 6:6 (Feb. 19) 1965.

Drugs and Blood Dyscrasias

By OVID O. MEYER, M.D.
Madison, Wisconsin

■ WITH THE GREAT increase in the use of drugs and chemicals for medical, agricultural, industrial, and household purposes, the hazards to susceptible and sensitive individuals have likewise multiplied. Three-fourths or more of the drugs which are now used medically have been made available only in the past 25 or 30 years, and though they are valuable, they tend to be potent and hence dangerous—particularly when there is unsupervised use by the patient. The Registry on Blood Dyscrasias of the Study Group of the Council on Drugs of the American Medical Association lists more than 400 drugs that have resulted in inducement of one or more types of blood abnormality. Obviously, the documentation varies, as does the frequency of occurrence of a particular dyscrasia owing to any specific drug.

Although chemicals have been charged with responsibility for the production of leukemoid reactions and polycythemia,[1] and on occasion macrocytic megaloblastic anemia because of administration of antimetabolites such as folic acid antagonists, 6-mercaptopurine, or 5-fluorouracil and anticonvulsant drugs such as diphenylhydantoin (Dilantin) and primidone (Mysoline),[2, 3] the most commonly recognized dyscrasias induced by drugs are:

1. Agranulocytosis
2. Thrombocytopenia
3. Aplastic or hypoplastic anemia
4. Hemolytic anemia

These essentially manifest themselves in morphological changes, but in addition other well defined changes of a chemical or vascular nature may occur and lead to purpura. For example, administration of acetylsalicylic acid or sodium salicylate produces hypoprothrombinemia, and several other drugs such as the coumarin compounds and indandiones can cause excessive hypoprothrombinemia in the unusually sensitive person, or when they are administered in excessive dosage. In addition, the indandiones on occasion can produce agranulocytosis, excessive hemolysis, and apparently thrombocytopenia.

The use of certain therapeutic agents in the treatment of patients with neoplastic diseases such as leukemias and malignant lymphomas characteristically causes a depression of the bone marrow, and hence some degree of peripheral blood change is inevitable. These agents are well known and include:

1. Ionizing radiation and radioactive elements, such as radioactive phosphorus and gold.
2. Alkylating agents such as nitrogen mustard, triethylene phosphoramide, triethylene melamine, and chlorambucil (Leukeran).
3. Antimetabolites
   Folic acid antagonists such as methotrexate
   Antipurines such as 6-mercaptopurine (Purinethol) and others
   Antipyrimidines such as fluorouracils
4. Benzol
5. Busulfan (Myleran)
6. Colchicine derivatives (Colcemid)
7. Phenylhydrazine
8. Urethan
9. Vinblastine (Velban) and vincristine (Oncovin)

Whenever one of these is given, careful attention to the blood status, the leukocyte count and platelets especially, is necessary. Leukopenia is most often first noticed.

Agranulocytosis. Agranulocytosis was first described as a syndrome by Werner Schultz in 1922. At one time it was considered relatively rare, but with the increasing use of coal tar products in therapy the number of

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

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cases multiplied. However, coincident with the observations of Kracke[4] and Madison and Squier,[5] a decrease in the use of aminopyrine (Pyramidon) was followed by a lower incidence of this entity.

Although the symptomatology, with leukopenia and neutropenia, is well recognized, a precise definition of agranulocytosis is difficult, and thus absolute unanimity is not available. However, with the febrile course and symptomatology, at the height of the disease the leukocyte count is probably less than 2,500 and the neutrophils less than 25 per cent.

Agranulocytosis may result from the administration of a drug which depresses the bone marrow, or it may result when the drug (such as aminopyrine or phenylbutazone) combines with a protein in the serum to form an antigen—with antibodies then being formed so that the cells are agglutinated and destroyed, owing to contact between the antigen and the protein-bound leukocytes. The older leukocytes are first destroyed by agglutination and lysis, and the bone marrow appears to be hyperplastic owing to an excessive demand for cell production because of increased peripheral cellular destruction.[6, 6a] The mechanism of cellular sensitivity is suggested in part by the fact that an individual can tolerate a drug such as aminopyrine with impunity on several occasions, but with the next ingestion acute agranulocytosis may occur.

Dameshek and Colmes[7] showed that symptoms and granulocytopenia could be reproduced when a small quantity of aminopyrine was readministered to sensitive individuals or to normal persons who had been given plasma from an aminopyrine-sensitive patient. Madison and Squier[5] had previously demonstrated in the sensitive individual prompt, 2-to-3-hour recurrence of symptoms and granulocytopenia following administration of Pyramidon in small doses.

A third type of mechanism for the production of agranulocytosis is that described by Pisciotta,[8] wherein chlorpromazine is responsible. Here there are no demonstrable leuko-agglutinins or leukolysins. The precise mechanism for production of the agranulocytosis is not known, but it does not appear to be an immunoallergic reaction. In these cases there is depletion of the bone marrow, and the effect usually follows prolonged treatment with large doses. It is probable that the individual's leukocytes are intolerant to this drug because of a metabolic abnormality in the blood-forming tissues. Pisciotta[9] suggests that this might be genetically determined. Other drugs of the phenothiazine group are also found to be capable of producing agranulocytosis.

In any of the blood dyscrasias many drugs, alone or in combination, may be etiologic. A list of drugs which are especially likely to cause agranulocytosis on the basis of drug sensitivity or host susceptibility is given below:

- Aminopyrine (Pyramidon)
- Antihistamines (Pyribenzamine)
- Chloramphenicol*
- Chlorpromazine and its derivatives
- Dinitrophenol
- Indandiones
- Meprobamate
- Oral hypoglycemic agents
- Phenylbutazone
- Sulfonamides
- Thiouracil-type drugs
- Trimethadione and other anti-convulsants

This list is by no means complete, and on rare occasions agranulocytosis could develop from drugs ordinarily considered nontoxic in the hematologic area, although other toxicity —for example, ototoxicity with streptomycin —is well recognized.

Thrombocytopenic Purpura. Thrombocytopenic purpura may result from drug toxicity, but purpura may also be due to damage to blood vessels. Quinine reputedly is capable of producing purpura, by this mechanism as well as by initiating thrombocytopenia. Although many drugs may induce thrombocytopenia by depressing platelet production, other drugs may occasionally cause increased platelet destruction.

Ackroyd[10] was able to demonstrate that the agglutination of platelets followed by lysis was the mechanism for the production of thrombocytopenic purpura when the hypnotic Sedormid was administered to a patient sensitized by previous administration of the drug. A marked fall in the platelet count can occur in 30 to 60 minutes. Ackroyd, and others since, have shown that, when Sedormid was added *in vitro* to the blood of patients who had recovered from purpura previously induced by the drug, in concentration corresponding to those achieved by oral administration, this lysis of platelets occurred. The thrombocytopenia following administration of quinine involves

* First observed by I. F. Volini, *et al.* before its role in aplastic anemia was noted (Proc. Cent. Soc. Clin. Res., Nov. 5, 1949).

a similar mechanism,[11] as does that with quinidine. Interestingly, there is no cross-sensitivity for these two drugs.

Although many drugs may occasionally produce thrombocytopenic purpura, those in common use that present this hazard are listed below:

(Chlorothiazide is most likely to produce nonthrombocytopenic purpura).

Acetazolamide (Diamox)
Anticonvulsants (Dilantin)
Chloramphenicol
Corticosteroids
Digoxin and digitoxin (rarely)
Hypoglycemic agents—chlorpropamide and tolbutamide
Meprobamates (Equanil, Miltown)
Penicillin
Phenylbutazone
Quinine
Quinidine
Ristocetin
Sedormid
Stibophen (Fuadin)—antimony compound
Streptomycin
Sulfonamides (several)

Hypoplastic or Aplastic Anemia. Although pancytopenia, a reduction in erythrocytes, leukocytes, and platelets, is characteristic of many common diseases—leukemias (especially the acute), miliary tuberculosis, pernicious anemia, Felty's syndrome and lupus erythematosus disseminatus—without hypoplasia of the bone marrow, our concern here relates to that which is symptomatic of a hypoplastic or aplastic marrow. Scott, Cartwright, and Wintrobe[12] contend that probably one-half of the cases of aplastic anemia are idiopathic; yet it is recognized that chemicals and drugs commonly used in medical therapy are capable of suppressing or obliterating the bone marrow—often irreversibly so—with demonstrable lack of all three formed elements of the blood. The mortality in aplastic anemia, when little functioning bone marrow remains, is distinctly high—over 50 per cent. The myelosuppressive agents are all capable of producing aplastic anemia if the dose is adequate longed. However, other drugs which can and/or the administration sufficiently procause hypoplastic or aplastic anemia are well known, although the mechanism(s) for their myelotoxicity is not clearly understood. Many insecticides, notably D.D.T., may also be responsible.

Some of these important drugs are listed below, but at present that of greatest importance in the production of aplastic anemia is the antimicrobial agent chloramphenicol. Fatalities have been frequent in this instance.

Chloramphenicol
Chlorpromazine and Promazine
Dinitrophenol
Gold preparations
Mesantoin (anticonvulsant)
Penicillin
Phenylbutazone
Sulfonamides (sulfanilamide, sulfapyridine, sulfathiazole)
Tetracyclines
Thiouracils

Chloramphenicol, in large enough doses, is capable of suppressing the bone marrow in nearly everyone. On the other hand, some individuals—children in particular—are highly susceptible, and even doses as small as 1 to 2 gm have caused aplasia in rare instances. Most often prolonged therapy or intermittent therapy appears to have been especially hazardous. McCurdy[13] has found that a fall in the reticulocytes in the peripheral blood anticipates depression of erythropoiesis, and he advises serial reticulocyte counts when chloramphenicol must be used. Rubin, Weisberger, and Clark[14] observed that the increase in plasma iron content and in the saturation of the iron-binding globulin, betaglobulin, precedes the fall in hematocrit by an appreciable period before the erythropoietic depression of chloramphenicol therapy occurs. Hence, these measurements serve as a reliable and sensitive index of erythropoietic toxicity, and if the treatment is stopped, marrow aplasia may be avoided.

Hemolytic Anemias. Although drugs such as phenylhydrazine and acetylphenylhydrazine regularly achieve their effect in the treatment of polycythemia by destruction of erythrocytes, in some rare cases of an acquired hemolytic anemia due to drugs there is a mechanism similar to that for agranulocytosis and thrombocytopenia. The erythrocytes are agglutinated and destroyed in the presence of the chemical because of the production of antibodies. Harris[15] has described the occurrence of an acute hemolytic episode which developed when the antimony compound stibophen (Fuadin) was readministered to a sensitized individual. The Coombs test was positive, and the serum contained agglutinating and hemolyzing factors in the presence of the *in vitro* and *in vivo* systems. Penicillin, quinine, quinidine, and acetophenetidine (Phenacetin) have been implicated in such hemolytic anemias.[16]

Despite the fact that these hemolytic anemias of hypersensitivity do occur, most cases cannot be explained by an immune mechanism; rather, they are associated with

a genetic defect within the erythrocytes characterized by multiple enzyme abnormalities. Notably, there is a deficiency of glucose-6-phosphate dehydrogenase, with a resultant low content of reduced glutathione (GSH). In 1954 Dern *et al*[17] demonstrated an erythrocyte abnormality which accounted for the hemolytic susceptibility to the antimalarial drug primaquine. This defect is greatest in the older red cells, and hence they are most susceptible and disappear first. The distribution of this defect is worldwide, and Kellermeyer *et al*[18] estimate that the abnormality probably affects more than 100 million people. The incidence is highest—60 per cent or more—in Kurdish Jews, and is higher in Negroes than in Caucasians in the United States; the lowest incidence is in Caucasians of non-Mediterranean origin. The abnormality is found in Asiatic Indians but not in North American Indians or Alaskan Eskimos. The degree of enzyme deficiency varies among races and families, and hence susceptibility to the 8-aminoquinolines and other chemicals and certain vegetable foods, notably fava beans, varies.

It has been demonstrated that there are other enzyme defects in the erythrocytes of Caucasians not observed in Negroes. Thus, erythrocyte acid phosphomonoesterase[19] is lacking in Caucasian erythrocytes and not in those of the Negro. This added deficiency probably accounts for the fact that Negroes are less susceptible to serious hemolysis than Caucasians and are unaffected by some drugs and by the ingestion of fava beans, which produce an acute intravascular hemolysis in Caucasians. Susceptible individuals, who can be detected in advance by several methods,[18] are prone to develop hemolytic anemia from many drugs—but, in particular, primaquine, nitrofurantoin (Furadantin), furazolidine, sulfisoxazole (Gantrisin), salicylazosulfapyridine (Azulfidine), sulfanilamide, sulfapyridine, sulfamethoxypyridazine (Kynex, Midicel), menadione sodium bisulfite (Hykinone), and aspirin, as well as certain vegetable foods such as fava beans. This susceptibility to hemolysis is enhanced in many circumstances, as, for example, in diabetic acidosis and when viral and bacterial infections exist. Thus a special alertness when administering medications is important.

Investigations in recent years have broadened the scope of our knowledge of mechanisms which account for drug-induced blood dyscrasias, and, although the complexities of the field have been increased, our understanding has been enhanced. The incidence, considering the widespread use of the drugs by large numbers of patients, is really not great; a frequency of 2 per cent or less has been suggested for any of the hematologic conditions here mentioned. Nevertheless, any individual case is likely to be serious, and the risk of death is considerable. It is especially important that the indications for the employment of any drug be clear and that indiscriminate usage, with prescribing of a drug where it is not needed or without value, be meticulously avoided. It is obvious that the more drugs given to a patient, the greater the risk of a reaction of one type or another—often hematologic.

It is important that when a reaction of any type is observed in a patient it be reported. Since no physician is likely to see any specific reaction frequently, it behooves him to report each one. Only from numerous individual reports will the doctor be alerted early to the precise incidence of reaction to any drug. This is especially important when a *new* drug is administered, since prompt recognition and reporting by the profession may prevent much disability and save some lives.

In 1954 the AMA Council on Drugs established a Blood Dyscrasia Registry. The FDA has maintained for some years an adverse-drug-reaction reporting system. Presently a good collaborative plan has been set up by the FDA and the AMA. Adverse reactions of any type, by no means limited to blood reactions, may now be reported on an official form to either agency, and the information will be made available to the other. The anonymity of the patient may be maintained, and yet it is possible, in the plan, to avoid duplication of reports. There will be prompt publication of this information. We as physicians should seriously concern ourselves, for the sake of our patients and our fellow physicians, with the drug toxicity occurring in recipients from the powerful agents that we use daily. We can minimize hazards by ascertaining that unfavorable reactions be made promptly known to the responsible agencies and thus to our colleagues everywhere.

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SURGERY THAT SHORTENS SMALL INTESTINE LOWERS CHOLESTEROL LEVELS IN 15 PATIENTS

One way to save a man's heart may be through his intestines.

So says Dr. Henry Buchwald, an established investigator of the American Heart Association at the University of Minnesota Medical School, who has developed an operation to shorten the small intestine as a means of increasing the elimination of cholesterol, thereby lowering the amount in the bloodstream.

High blood levels of cholesterol and other fats are associated with an increased risk of heart attacks. Whether a drop in cholesterol levels will lessen the risk is still open to question, however.

The operation devised by Doctor Buchwald creates a detour around the lower third of the small intestine, the site where most of the cholesterol taken in through the diet or made by the body is normally absorbed into the blood. As the result of the operation, instead of entering the bloodstream, the cholesterol passes into the large intestine and is excreted.

Recently Doctor Buchwald gathered preliminary evidence that in rabbits this intestinal bypass surgery not only causes cholesterol levels to drop sharply but apparently also arrests the development of atherosclerosis.

Since 1963—after having established in laboratory animals that a similar operation did lower blood cholesterol—Doctor Buchwald and his associate, Dr. Richard Varco, have performed intestinal bypass surgery on 15 patients. Most were in their 30s and 40s, had very high cholesterol levels and had already had one or more heart attacks. Three patients were operated upon who had not yet had a heart attack but who seemed to run an especially high risk. Each of these patients had an excessively high blood cholesterol level and belonged to a family with a history of many heart attacks.

Following surgery all patients showed a significant drop in cholesterol levels—averaging about 40 per cent. From levels of 280 to 600 (milligrams per cent), their cholesterol readings have fallen to a mean of about 200 postoperatively. The average figure in the U. S. is about 230.

Doctor Buchwald said in an interview that surgery was not performed in these patients until every dietary means of reducing cholesterol levels had been tried. He added that it is still too early to tell whether the operation will help halt the atherosclerotic process in these patients as it appears to have done in rabbits.

Doctor Buchwald said that he may also have seen some signs that the atherosclerotic process in rabbits alive nearly two years after surgery has been reversed—but calls his evidence "still far from conclusive".

Attempted Suicide by Chemical Agents

By R. D. NASHOLD, M. S., Madison, Wisconsin

THE DIVISION of Health Education of the Wisconsin State Board of Health has obtained reports on poisoning through the excellent cooperation of 46 hospitals in 1963 and 49 hospitals in 1964. These hospitals are estimated to serve approximately one half of Wisconsin's population. For the two years 1963 and 1964, a total of 7,032 cases* of poisoning were reported with 773 of these (over 10 per cent) reporting suicidal intent. It is reasonable to assume that the numbers would nearly double if all hospitals in Wisconsin reported poisoning cases. The total would still exclude all cases treated in the private offices of physicians, and in clinics, as well as those cases that never receive professional medical attention. In instances of suicidal intent there may also be an attempt by the patient or patient's family to withhold information. It becomes apparent that in Wisconsin attempted suicide by poison, even apart from mortality, represents a sizeable problem of broad significance.

To help define the problem of poisoning with suicidal intent it is necessary to look at characteristics of the patients. First, they are largely adolescents below the age of 20 or young adults ages 20 to 34; second, more than three-fourths (78 per cent) are female (Table 1).

Adolescence is a particularly critical period of growth and development; and young adults are faced with the fundamental problems of job and mate selection. Frustrations from these problems and others may precipitate the depression usually associated with attempted suicide or actual suicide.

The fact that 79 per cent of the attempts among youth below the age of 25 are female can be explained to some extent. First, it is recognized that poisoning, particularly by analgesic and soporific drugs, is a preferred female method of attempting suicide. Males are likely to use other and usually more violent methods, such as firearms. If males attempt suicide by poison, it is more likely to be by motor vehicle exhaust. Young males are also suspected of more indirect suicide by deliberate recklessness while driving a motor vehicle. A suicide under the latter circumstances would almost invariably be considered an accident.

TABLE 1—*Cases of Poisoning Reporting Suicidal Intent by Age and Sex, Wisconsin, 1963–1964*

Age Group	Male		Female		Unknown Sex	Total	
	Number	Per cent	Number	Per cent		Number	Per cent
Below 15	5	3.3	23	3.8	2	30	3.9
15–19	33	21.7	135	22.4	5	173	22.4
20–24	30	19.7	122	20.3	1	153	19.8
25–29	17	11.2	77	12.8	3	97	12.5
30–34	16	10.5	68	11.3	2	86	11.1
35–39	12	7.9	40	6.6		52	6.7
40–44	6	4.0	44	7.3		50	6.5
45–49	6	4.0	33	5.5	1	40	5.2
50–54	9	5.9	18	3.0		27	3.5
55–59	4	2.6	12	2.0		16	2.1
60–64	4	2.6	7	1.2		11	1.4
65+	4	2.6	8	1.3		12	1.6
Unknown	6	4.0	15	2.5	5	26	3.4
Total	152	100.0	602	100.0	19	773	100.0
Per cent by Sex		19.7		77.9	2.4		100.0

The second factor to be considered about the predominance of female attempts is that premarital sexual involvement is likely to have greater immediate consequences for the female. Many of the reports of attempted suicide among unmarried women mention pregnancy or fear of pregnancy as the reason. If the woman is pregnant and does survive, questions as to possible effects on the fetus remain unanswered.

If such a large number of persons are attempting suicide by poison, how many result in death? Mortality statistics show that for the two years 1963 and 1964 there were 200 poisoning deaths† reported as suicide. However, only 40 per cent of these are suicides by ingestion of solid or liquid substance, the other 60 per cent are by gases. It should also be noted that reporting of suicides is estimated to be from one-fourth to one-third incomplete.‡

Making no allowance for under-reporting and excluding suicides by gases, a comparison of deaths by suicide with attempted suicides shows that for every death due to suicide by ingestion of solid or liquid substance there are approximately 10 attempted suicides. Table 2 also shows that the ratio of attempts to deaths for females is much higher than for males, and that for both males and females the ratio declines as age increases. Beyond age 60 the ratio of attempts to deaths is the same for men and

* Case does not mean all persons showing symptoms of poisoning but rather all persons who ingested a toxic substance or in cases of preschool children, those who were believed to have ingested a toxic substance.

† Although the number of deaths is small for the age group 15–19, suicides rank third among leading causes of death for this age group, exceeded only by accidents and cancer. For the age group 20–34, it ranks fourth, being exceeded by accidents, cancer, and diseases of the heart.

‡ Dublin Louis I, *Suicide A Sociological and Statistical Study*, The Ronald Press Co., 1963, page 3.

TABLE 2—*Ratio of Attempted Suicide to Deaths by Suicide for Poisoning by Solid or Liquid Substance by Age Group and Sex, Wisconsin, 1963–1964*

Age Group	Male			Female			Total		
	Deaths[1]	Attempts[2]	Ratio[3]	Deaths[1]	Attempts[2]	Ratio[3]	Deaths[1]	Attempts[2]	Ratio[3]
Below 20	1	38	38	2	158	79	3	203	68
20–29	4	47	12	4	199	50	8	250	31
30–39	9	28	3	9	108	12	18	138	8
40–49	6	12	2	14	77	6	20	90	5
50–59	6	13	2	10	30	3	16	43	3
60+	5	8	2	7	15	2	12	23	2
Total	31	152	5	46	602	13	77	773	10

[1]Mortality data is obtained from death certificates filed with the Division of Vital Statistics, State Board of Health.
[2]Total attempted suicides include 21 persons for whom age is unknown, 14 persons for whom sex is unknown, and 5 persons for whom both age and sex is unknown. Rows and columns therefore, cannot be added to obtain row and column totals.
[3]Ratios are calculated by dividing attempts by deaths for each age–sex group.

women. The highest ratio obtained is for adolescent females.* This high ratio suggests that a large number of the attempts are in fact "suicidal gestures." Although most of the attempts may be of an impulsive nature resulting from an emotional crisis and not a desire to die, they may end fatally due to miscalculation or failure to obtain prompt or appropriate treatment.†

CONCLUSION. Attempted suicide by poison presents a serious problem not only in terms of mortality but also as an indicator of the mental health of our population. The problem stands out among youth, especially young women, and should, therefore, be a concern of those who have major responsibilities for the well-being of this group, including parents, teachers, physicians, and others.‡

* A ratio of 100 attempts for each death was reported for adolescents in New York City.

† See Jacobziner, Harold, M.D. "Attempted Suicides in Adolescence," *Journal of American Medical Association*, Jan. 4, 1965, Vol. 191, No. 1
If reporting of suicidal attempts and deaths were complete for Wisconsin, the ratio might be similar.

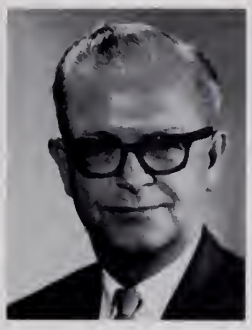
‡ Danger signs and prevention efforts are also discussed in the JAMA Article listed above.

THE LABORATORY IN DISEASE PREVENTION

Do you use your local laboratory or if not available, the State Laboratory, for the prevention of disease?

1. Do you do a PAP test at least every 2 years on every woman over 20? Does your hospital do them on every adult female admission?
2. Do you take a throat culture on every patient with a sore throat in the 5 to 20 age group and if streptococcal, advise penicillin for 10 days?
3. Do you do a VDRL test for syphilis, at least in the high risk group: the suspicious case, the contact, the widowed and divorced, the pregnant, the non-white, the lower socioeconomic group, and on every adult hospital admission?
4. Do you examine a smear and/or take a culture on every bacterial infection prior to starting antibiotic therapy, and do sensitivity tests when indicated?
5. Do you submit the brain of every suspected rabid animal involved in human exposure to the State Laboratory? And know WHO recommendations, particularly the use of horse immune serum and duck embryo vaccine?
6. Do you do phage typing in outbreaks of staphylococcal infections in your hospital after a careful epidemiological evaluation has been done? And have a laboratory record system for surveillance of staphylococcal infections?
7. Do you send proper specimens for viral diagnosis to the State Laboratory in all community outbreaks of infectious disease, in all hospitalized cases of viral meningitis and encephalitis, and in any unusual exanthem?
8. Do you do enteric cultures for Salmonella, Shigella and E. coli on any outbreak of diarrhea or any protracted episode in an individual?
9. Do you do sputum cultures and PPD tests on all patients with undiagnosed pulmonary infiltrates?
10. Do you regularly test for diabetes, at least in high risk groups: unaccounted weight loss, clinically suspicious, recurrent boils, relatives of diabetics?—LABORATORY NEWSLETTER, Wisconsin State Laboratory of Hygiene, May 1965.

THE PRESIDENT'S PAGE . . .



J. H. HOUGHTON, M.D.
Wisconsin Dells

Phenylketonuria (PKU)

■ DURING THE PAST YEAR, and especially in the last Wisconsin legislative session, there has been quite a to-do about phenylketonuria (PKU). The Junior Chamber of Commerce, PTA groups and sundry organizations have enthusiastically caught up the banner and joined the parade to enact legislation to make tests for PKU mandatory in the newborn.

What is PKU? As all doctors know, PKU is a metabolic disorder in which the human body is unable to convert phenylalanine into tyrosine. Tyrosine is one of the essential amino acids, and apparently is necessary for proper brain development. The exact mechanism is not known.

The impression has been created, whether willfully or by chance, that the doctors are against the tests. This could not be further from the truth. As doctors, we are 100% for the tests, but we are against making it mandatory. Every doctor who is worthy of the title he has earned will do everything within his capabilities to detect disease, treat it, or prevent it. We are opposed to the proposed legislation for two reasons. One, because we are afraid of establishing a precedent for legislation involving new diseases as they are discovered. Two, because the currently proposed legislation might induce a sense of false security about negative results. Even the most enthusiastic pathologists agree that the Guthrie test is not confirmative before the 4th or 5th day of life. This test may be misleading if performed earlier. With the average patient going home on the 3rd and 4th or 5th postpartum day, how reliable is this test? Furthermore, we believe that this is a doctor's responsibility. The present proposed legislation makes it the responsibility of the hospital administrator.

A rational approach is that submitted by Doctor Harry A. Waisman (*Wisconsin Medical Journal*, August 1965, p. 278) and is summarized as follows:

(1) Guthrie test in hospital on 4th or 5th day, if baby stays that long.
(2) Phenestix or Fe Cl 3 test between 10th and 14th day at doctor's office.
(3) Phenestix Fe Cl 3 test at 4th week at doctor's office.

If positive results are obtained from any of these tests, these must be confirmed by a quantitative blood phenylalanine test before treatment is instituted.

Many other metabolic diseases of the newborn are being recognized; and it may well be that in the not too distant future, an earlier postnatal examination will be indicated, not only for PKU but also for the detection of such disorders as galactosemia, histidinemia, maple syrup urine disease, homocystinuria, and the like. The proper approach to the detection and prevention of the damage caused by these disorders is education, not legislation. Education applies to the exchange of information between the medical researchers and the practicing physicians as well as to the proper information given to the public.

Let's keep the responsibility where it belongs—with the doctors and not the legislators. Let the avenues of communication between the medical educators and researchers be broadened and paved, if you will, with understanding and cooperation so that exchange of information is more readily available to both groups. And let the nonmedical public be benefited by the knowledge and information available to both groups.

J. H. Houghton, M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Views expressed, if initioled or signed, are those of the writer ond not necessorily officiol positions of the Society.

Laudable Collaboration

■ DESPITE WHAT SEEMS to be a trend toward antagonism between practitioners of private medicine and the government, bright spots of cooperation continue to appear. One of the most encouraging was the establishment of a registry of tissue reactions to drugs, announced last Spring.

At the present time both the American Medical Association and the Food and Drug Administration maintain registries which receive reports of suspected adverse drug reactions. The FDA draws from about 500 federal and military hospitals and 110 civilian hospitals under contract. The AMA receives reports from physicians in private practice and those hospitals which do not report to the FDA. Both organizations trade information.

Under the new registry, which will be set up within the Armed Forces Institute of Pathology in Washington, all reports of adverse reactions will be studied, referenced and filed in one central location. According to the plan, autopsy or biopsy specimens will be exhaustively studied, and the results of the studies will be reported to local pathologists who furnished the material. Monthly reports will be made to the sponsoring organizations, and important information will be passed on to the medical community.

Although the tissue registry is established within a government agency, it is significant that two of the sponsoring — and financing — organizations are private associations, which, more often than not, are associated in the public press with opposition to the government. One is the AMA and the other is the Pharmaceutical Manufacturers Association.

The cooperation of two of the most important proponents of private enterprise in the medical community with a government agency, when such cooperation is in the public benefit, should demonstrate the community-oriented attitude of private medicine. Unfortunately, this point was glossed over last Spring; instead, public attention was focused on the split on "medicare."

Nevertheless, with or without publicity, this kind of cooperation gives evidence of the sense of social responsibility of the private groups interested in health care. While the work of politicians and social reformers may

appear to separate elements of the medical community, the fact remains that only by the increasing cooperation of those elements can progress be made in the field of health care. —D.N.G.

Heal-in, Heels-out

FOR SHEER FOOLISHNESS, there has been little in recent medical history to equal the so-called "heal-in" that occurred in Los Angeles County General Hospital a few months ago. A group of house staffers with a grievance against the hospital administration admitted as many patients as they could and kept the patients already admitted as long as possible. The idea, apparently, was to jam the hospital with an intolerable population in order to demonstrate the muscle the doctors could flex if the hospital didn't agree to their demands.

Without considering the merits of their grievances, we can only abhor the technique. No doctor, either alone, or in conspiracy with others, has the right to use his patients as pawns in an argument with a hospital, an agency, or an institution of any kind. His judgment as to whether a patient should be admitted or released from a hospital must be determined by the requirements of the patient—and nothing else. If any extraneous consideration affects his judgment, the doctor is as much a charlatan as a snake oil peddler.

It is to be hoped that the universally negative reaction to the Los Angeles group will deter any recurrence of this vicious practice. But if it does happen again, local medical societies and the American Medical Association should show ethical responsibility by taking appropriate action against those who undertake this dangerous conspiracy. —D.N.G.

Our Thanks to:

The AMA News
The Medical Tribune
Minnesota Medicine
Iowa Medical Journal
Nebraska Medical Journal

ONE OF THE MORE exciting and valuable projects of the Charitable, Educational and Scientific Foundation, Inc., of our Society is the development of the Museum of Medical Progress and the Stovall Hall of Health, located in the medically historic city of Prairie du Chien, Wisconsin, on the shores of the Mississippi River.

Earlier this year it was decided that visually telling the story of Laennec and his discovery of the stethoscope would prove to be a valuable exhibit, educationally and historically . . . IF done in such a manner as to engage the interest of thousands of youngsters who visit the Museum and the Hall of Health annually.

But realism is important. So the total exhibit, when completed, will include a diorama of Laennec and his first use of the stethoscope, and then a series of actual stethoscopes depicting dramatic improvements over the years to the point of the transistorized one of today. With the use of telephones, the visitor will be able to *hear* those improvements.

But where to find old timers?

The CES Foundation developed an ad-type request, reproduced here. Our fellow publishers listed above ran this announcement without charge. And the stethoscopes, exactly of the type we wanted, began to arrive.

WANTED FOR DISPLAY

OLD TIME STETHOSCOPES

WE HAVE THESE FOUR

Will you donate others to the

Museum of Medical Progress & Stovall Hall of Health

Prairie du Chien, Wisconsin

Please write: The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701

In some future page on Medical History in the *Wisconsin Medical Journal*, or in the Newsletter to members of the Section on Medical History, we will tell more of this project and of the stethoscopes.

In the meantime, thanks to our fellow publishers. You showed the power of the press! —C.H.C.

GUEST EDITORIAL

AMA Clinical Convention

THE AMERICAN PHYSICIAN is well aware that he must keep abreast of new findings in therapy and research to be able to provide the best possible care for his patients.

He must know about new drugs and their uses and possible side effects. He must know about new techniques of surgery. He must know of the promising leads toward solution of now baffling physical ills. And he must know of the sometimes small but often important new successes in finding better ways to treat the already treatable diseases.

There's no argument about the premise that the physician must keep learning. The problem is how. With the average American physician now working a 58-hour week, and many putting in hours far above the average, how can the physician find the time to study and keep abreast?

One of the most compact methods of checking up on new developments is to attend the annual clinical convention of the American Medical Association. The program of this convention is designed primarily for the man in practice. The speakers will read papers that bring to the man in practice the latest findings of others in his area.

This year the clinical convention will be held in my home state of Pennsylvania, Nov. 28–Dec. 1, in Philadelphia.

The Philadelphia meeting offers an excellent scientific program. Topics of wide interest will be discussed by outstanding teachers. All of the various sessions and workshops will contribute to the continuing education of the practicing physician.

Particularly noteworthy are the postgraduate courses in gynecology and obstetrics and in cardiovascular therapeutics, consisting of two series of comprehensive lectures.

Other sessions will be devoted to timely subjects, followed by question-and-answer or discussion periods. Fireside conferences and breakfast roundtables will provide further time for informal discussion.

It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the clinical convention.—JAMES Z. APPEL, M.D., *President*, American Medical Association

LETTERS

PROJECT VIET-NAM

To SMS:

In response to an urgent appeal to American Medicine by President Lyndon B. Johnson, the American Medical Association is assisting the newly formed voluntary organization known as PROJECT VIET-NAM. This Project, administered by The People-to-People Health Foundation, Inc., is a cooperative medical effort of America's inter-voluntary agencies for the people of South Viet-Nam. The Agency for International Development (AID) is also participating in this program that appears vital to our success in the present crisis in Asia.

PROJECT VIET-NAM was developed to help alleviate the problem of the critical shortage of physicians in South Viet-Nam—a problem that is crippling and demoralizing the civilian population of the country. The matter is of concern to all physicians—those believing that human life everywhere is sacred, and those sharing a stake in the security of the United States. The American Medical Association, cooperating with the President's request, is appealing to each County and State Society for participation in a program that will assist in the procurement of volunteer physicians for this important venture.

. . . While ultimately many disciplines of medicine may be required, the immediate need is for physicians in *general practice*, *general surgery* and *orthopedic surgery*.

. . . Interested physicians may obtain further information and application forms by communicating with:

PROJECT VIET-NAM
2233 Wisconsin Avenue, N.W.
Washington, D.C. 20007
Phone: 338–5730 or 338–6110

I ask your help in the medical support of valiant people playing a decisive role in the defense of freedom, not only in Southeast Asia, but in all the world.

JAMES Z. APPEL, M.D.
President
American Medical Association

Minutes of Council Meeting

MILWAUKEE, MAY 2, 1965

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. at the Sheraton–Schroeder in Milwaukee on Sunday, May 2, 1965.

All voting members were present: Doctors James, Schulz, Nordby, Davis, Stoops, Dessloch, Blanchard, Kief, Nadeau, Fox, Bell, Mason, Frank, Ekblad, Lee, Chojnacki, Hollenbeck, W. J. Houghton, Van Hecke, Wright, Past President Egan, President Curran, and Speaker Callan.

Others present were: President-Elect J. H. Houghton, Treasurer Weston, Vice-Speaker Behnke; Doctors Bernhart and Galasinski, AMA delegates, and Picard, alternate; Doctors Stovall, Simenstad, and W. T. Russell, reference committee chairman; Messrs. Crownhart, Ragatz, Koenig, Maroney, Hansen, Reynolds, Ryder, Waldschmidt, Murphy, Kluwin, White, and W. J. Brown, AMA field representative; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes, March 13–14, 1965

On motion of Doctors Curran–James, carried, these minutes were approved.

Commission on State Departments Elections

By separate motion duly made, seconded and carried, the following were elected for the ensuing year:

T. W. Tormey, Jr., M.D., Madison, general Chairman
W. J. Egan, M.D., Milwaukee, vice-chairman
A. M. Hutter, M.D., Fond du Lac, Division on Aging
H. A. Anderson, M.D., Stevens Point, Division on Chest Diseases
J. W. Nellen, M.D., Green Bay, Division on Handicapped Children
John R. Evrard, M.D., Milwaukee, Division on Maternal and Child Welfare
C. A. Wunsch, M.D., Green Bay, Division on Nervous and Mental Diseases
H. W. Carey, M.D., Lancaster, Division on Public Assistance
P. A. Dudenhoefer, M.D., Milwaukee, Division on Rehabilitation
R. B. Windsor, M.D., Sheboygan, Division on Safe Transportation
J. C. H. Russell, M.D., Fort Atkinson, Division on School Health
Meyer S. Fox, M.D., Milwaukee, Division on Visual and Hearing Defects

4. Armed Forces Rejectees Health Counseling Program

The Council had been provided with details regarding this program which will be administered in Wisconsin by the State Department of Public Welfare with federal funds for counseling only, and not for any treatment. The Society had been asked to endorse the program and cooperate in its development.

On motion of Doctors Schulz–Chojnacki, carried, the Council agreed to endorse the program provided its administration is conducted in a manner that will not disturb normal patient-physician relationships; that the Society be apprised periodically as the program develops, and reserves the right to reassess the program from time to time and withdraw endorsement should circumstances warrant. Such action contemplates Society cooperation in any appropriate manner.

5. Conference on Health Fads and Fallacies

A report on the April 8 conference in Green Bay was distributed to the Council, containing recommendations on the future of such conferences. Since only the chairman and one other member of the Commission on Public Policy had reviewed the report, the Secretary suggested that it not be forwarded to the House until the entire Commission has acted on it before the interim session.

On motion of Doctors Nordby–Nadeau, carried, the report was tabled by the Council.

6. Commission on Hospital Relations and Medical Education

The Commission's report had not been forwarded to the House but was submitted first to the Council. It dealt with two subjects:

A. Proposed Model Contract Between a Wisconsin Hospital and a Physician Practicing an "In-hospital Specialty"

The model as recommended by the Commission was discussed in detail and some further editing suggested.

On motion of Doctors Nordby–Nadeau, carried, it was approved as a model to be considered by and suited to the purposes of those using it.

While the report of the Commission referred to the contract being submitted to the Council, it was not intended for distribution to the House of Delegates.

B. Town-Gown Symposia

On motion of Doctors Nordby–Kief, carried, the Council approved the recommendation in the report of the Commission on future town-gown conferences. (See House proceedings for report and action.)

Doctors Nadeau–Kief moved that the Commission's recommendation that the two medical schools be represented in the House of Delegates be declined.

A subsidiary motion by Doctor Dessloch to lay on the table carried.

7. Financial Statements

A. Report of Treasurer

Doctor Weston presented his annual report of the Society's general fund as it would be given to the House of Delegates at the first session.

It was accepted on motion of Doctors Dessloch–Chojnacki, carried.

B. Certified Statements

Mr. John White, CPA, presented certified financial statements of the Society, its divisions and affiliated organizations, as requested by the Reference Committee on Reports of Officers.

On motion of Doctors Nordby–Blanchard, carried, they were accepted for transmittal to the House.

8. Inhalation Therapy

On motion of Doctors Kief–Hollenbeck, carried, the Council referred to the Commission on Hospital Relations and Medical Education an opinion of legal counsel with reference to inhalation therapy by a specially trained but unlicensed individual, with the

be billed by the institution, group, or individual providing such technical services, and be it further

"*Resolved*, That all insurance carriers operating in the State of Wisconsin be informed of the intention of the members of this society to bill patients for professional services beginning January 1, 1966, so that such carriers can arrange to provide appropriate coverage for their policyholders if they so desire, and be it further

"*Resolved*, That the Council of the State Medical Society of Wisconsin be requested to advise the Wisconsin Hospital Association that contractual agreements between hospitals and radiologists should be revised to conform with the principles stated herein."

On motion of Doctors Nordby–Dessloch, carried, the Council approved this action in principle and offered the good offices of the Society to arrange such conferences as will be necessary to implement it.

Mr. Crownhart said that he and Mr. Koenig were pledged to revise WPS, through the Commission on Medical Care Plans, to accommodate the action in any way it can, and Doctor Van Hecke indicated that by the time the Commission begins to meet on the matter, the pathologists will have made a statement on it.

7. Councilor Resignation

Doctor Dessloch said that with knowledge and approval of his district he had decided to resign from the Council at this time, and nominated H. W. Carey, M.D., of Lancaster as his successor; seconded by Doctor Nadeau and carried.

Doctor Nordby said it was a sad day to see so many good members of the Council leaving, in spite of their able replacements, and moved that the Council place on its minutes its grateful appreciation for their many years of excellent service; variously seconded and carried.

8. Adjournment

The meeting adjourned at 12:10 p.m.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

TRAVEL TIPS

The international traveler and the student bound for a summer abroad or a year in a foreign school now prepare for their journeys. Prevention is the key to maintaining health and to enjoy and profit from the experience. This involves immunizations, observation of certain simple health rules, moderation in eating and drinking, and exercise.

Immunizations: Successful smallpox vaccination within 3 years is required of all and must be endorsed by a local or state health official on an "International Certificate of Vaccination." All travelers, as well as the stay at homes, should have tetanus and diphtheria immunization up to date; there is now a special combined preparation for adults. Oral poliomyelitis vaccine is advised for all and typhoid-paratyphoid inoculations are especially desirable for the foreign traveler.

Measles vaccine, especially a live virus preparation, is desirable for children and perhaps adults who have not had the disease. Short-term protection for 3 to 6 months against infectious hepatitis can be obtained by gamma globulin, 0.02 to 0.06 ml/lb of body weight; its use should be considered for more prolonged visits in certain countries, especially the underdeveloped countries and when the visitor will have close contact with the native residents. Individuals working closely with school children and adults in less developed countries where tuberculosis rates are high should also consider BCG vaccination with their physician if their PPD skin test is negative.

Prophylactic rabies vaccination may be desirable for certain heavily exposed persons in high risk areas over long periods. Cholera and yellow fever protection is required for certain parts of the world. This and other important information are given in a USPHS pamphlet. "Immunization for International Travel", at $0.35 from Superintendent of Documents, Washington, D. C. 20402.

Health Rules: Enteric infections and "traveler's diarrhea" pose special hazards. In warmer climates and less developed countries eat only thoroughly cooked foods, drink only boiled or treated water, and be sure the milk and milk products are pasteurized. Avoid lettuce, water cress, and other raw foods grown in the area in which human fertilizer may be employed; avoid raw sea food such as oysters and clams which may result in Salmonella, typhoid, or infectious hepatitis; avoid cream pastries, ham, warmed over foods in warm countries with poor refrigeration facilities because of the danger of staphylococcal infection.

For the treatment of water the traveler is well advised to carry a bottle of inexpensive chlorine tablets (Halazone tablets—1 per quart, wait 30 min) or a bottle of ordinary tincture of iodine (1 drop/glass of water; wait 10 min). Iodine tablets are also available (Globaline, Potable-Aqua). Soft drinks (Coca-Cola, Pepsi Cola) are almost always safe, and beer and wine are often happy substitutes for questionable water. Overenthusiastic sampling of native foods should be discouraged unless thoroughly cooked and/or prepared under conditions known to be sanitary.

Two valuable health pamphlets for the traveler are: (1) Health Hints for the Tropics, $0.50, available from Editor, Tropical Medicine and Hygiene News, National Institutes of Health, Bethesda, Maryland (published by Waverly Press) and (2) Health Guide for Travelers, $0.50, Consumers Union of U.S., Inc., Mount Vernon, N.Y. In addition, the long-term visitor may be able to obtain a copy of the Peace Corps Manual, "A Guide to Health," from the Health Training Board, Peace Corps Medical Program Divison, Washington, D.C. 20525.—LABORATORY NEWSLETTER, Wisconsin State Laboratory of Hygiene, April 1965.

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REPORTS AND PROCEEDINGS OF 1965 ANNUAL SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin
MAY 3-5, 1965

Supplement to WISCONSIN MEDICAL JOURNAL
September 1965

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REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT THE ANNUAL SESSION

State Medical Society of Wisconsin May 3–5, 1965

The Annual Session of the House of Delegates of the State Medical Society of Wisconsin was held at the Hotel Schroeder in Milwaukee, Wisconsin, May 3–5, 1965.

Presented below are reports submitted to the House. Following these reports are the Proceedings of the House which include the recommendations of the reference committees and the House actions on these reports.

■ REPORT OF COMMISSION ON STATE DEPARTMENTS—May, 1965

T. W. Tormey, Jr., M.D., Madison, Chairman
L. M. Simonson, M.D., Sheboygan, Vice-Chairman
A. M. Hutter, M.D., Fond du Lac
H. A. Anderson, M.D., Stevens Point
J. W. Nellen, M.D., Green Bay
John R. Evrard, M.D., Milwaukee
Charles A. Wunsch, M.D., Green Bay
H. W. Carey, M.D., Lancaster
Paul A. Dudenhoefer, M.D., Milwaukee
Richard B. Windsor, M.D., Sheboygan
James C. H. Russell, M.D., Fort Atkinson
Meyer S. Fox, M.D., Milwaukee

The Commission on State Departments, is designed to coordinate the work of the ten Divisions reporting to it and to facilitate uniform reporting and exchange of information to the agencies of state government seeking its counsel. For the May, 1965, session of the House of Delegates eight out of ten Divisions are reporting.

It would be an inadvisable undertaking to attempt to cover all of the activities of the different Divisions that have come to the attention of the Commission, but the members feel that certain measures warrant emphasis.

The Commission recommends acceptance of the report of the Division on Aging and feels that it should continue its work in the field of nursing home accreditation, and also its interest in community based versus hospital based coordinated home care programs. It is also suggested that the Division conduct a workshop devoted exclusively to the problems of reemployment of the retired and of existing retirement programs.

The Commission recommends that the Division consider sponsoring a one-day workshop on the medical aspects of nursing home care and that this workshop concern itself with (1) rehabilitation of the older patient, (2) emotional problems of the aging, and (3) the use of drugs in treating older patients. The Commission feels that the Division should investigate the feasibility of conducting this program and report its findings for implementation in the fall of 1965.

The Commission concurs with the Division on Visual and Hearing Defects in its philosophy that physicians should be concerned with the physical impairment of vision rather than with the resulting visual disability and that this should be the continuing basis for its work with the Wisconsin Industrial Commission.

The Division is also encouraged to go ahead with a series of one-day courses of Hearing Conservation in Industry that have been previously approved by the House of Delegates.

The Division on Maternal and Child Welfare's report on nurse responsibility in obstetrics and gynecology is a significant accomplishment in an area that has long needed attention. The results of this study will serve as a guideline for medical staffs of hospitals to determine local rules in relationship to obstetrical care by nurses and physicians.

The Maternal Mortality Study Committee's tapes on subjects relating to maternal demise are highly recommended to the physicians of the state and the Commission feels that the availability of these tapes and the "Statement on Nurse Responsibility" should be published in the WISCONSIN MEDICAL JOURNAL. (The list of tapes appeared in the June issue of the WISCONSIN MEDICAL JOURNAL at page 220; the statement on nurse responsibility appeared in the July issue at page 262.)

The Commission supports the position of the Division on Maternal and Child Welfare in testing for phenylketonuria and with its position that when a physician is required to report suspected cases of abused children, the physician should be entirely free from threat of legal action.

The Division on Chest Diseases has considered Resolution No. 25, presented at the May, 1964, session of the House of Delegates and recommends that this measure be tabled. This Resolution asked that the State Board of Health be required to change its reporting form sent to those examined at mobile units to indicate that the follow-up examination would be conducted by a private physician and that a charge for this service would be made. Before making its recommendation, which the Commission supports, the Division sought an evaluation of the problem presented by Waupaca County and found that none of the evidence indicated that this was more than an isolated complaint and in many instances a follow-up is not paid for when the person is on relief.

The Commission is in agreement with the Division in their statement that hospital admission x-rays should be provided by all Wisconsin hospitals and recommends the position adopted on the hypertension screening program.

The Commission has accepted the report of the Division on Handicapped Children and notes that the Division has reviewed a program of assistance in the area of cystic fibrosis. It has also considered a proposed extension of services for specific congenital anomalies where unusual medical costs are associated with illness of children, and they are within the scope of activity of the Bureau for Handicapped Children. These programs are predicated upon a specific request by the family physician for assistance. (Announcement of this new medical care program appeared in the April issue of the WISCONSIN MEDICAL JOURNAL at page 167.)

The Commission feels that the work of the Division on Nervous and Mental Diseases in the field of proposed community mental health programs is vital to all physicians and it is recommended that the Society take an active interest in the establishment of these programs. The Commission concurs with the Division in suggesting that the Mental Health Advisory Committee of the State of Wisconsin should at all times have adequate physician representation, and further encourages postgraduate education programs be attempted in the ensuing year as they were in the past in Sheboygan and Green Bay. It is recommended that the Division on Nervous and Mental Diseases continue a survey of the practices and professional activities of private psychiatrists and that it continue consideration of postgraduate education on treatment implementation of alcoholism in local communities.

Proposed legislation to allow welfare departments to pay a private psychiatrist hospitalizing a welfare patient in a psychiatric ward in a private hos-

pital is supported by the Commission as recommended by the Division.

The Commission also feels that the Society should consider the feasibility of allocating funds for a full time staff man in the area of mental health and that it provide secretarial services and travel expenses for this office.

The Division on Safe Transportation's interest in the physician's role in traffic safety, and the medical limitations on driver licensing has been reviewed. The Commission accepts the report of the Division on Safe Transportation, but recommends that the Division study the various proposals regarding medical limitations on driver licensing with the idea of investigating whether or not it is feasible to implement the desired medical examinations through the State Board of Health as a matter of public health rather than through the police enforcement procedure.

The Division on School Health has undertaken several projects that have previously been approved by the Council and has also prepared, in cooperation with the Wisconsin Interscholastic Athletic Association, a guide on "Athletic Disqualification—Junior and Senior High School." The Council has previously recommended distribution of this guide. The Commission on State Departments points out the distribution of the "Guide for Athletic Disqualification" as a good example of the many projects carried on between sessions of the House of Delegates and would like to recommend to the Council that when it is considering specific recommendations of a particular Division, that it ask for representation from that Division to present the work that has been done and the reasons for the conclusions suggested. (The guide was published in the January issue of the WISCONSIN MEDICAL JOURNAL at page 28.)

The Commission would like to further recommend that the Commission on Public Policy ask for a spokesman from a Division when it is considering legislation that has been reviewed by a Division in detail and where the Division has a recommendation for Public Policy's consideration.

FISCAL NOTES FROM THE DIVISIONS OF THE COMMISSION ON STATE DEPARTMENTS

(See at end of each Division report.)

REPORT OF DIVISION ON AGING of Commission on State Departments —May, 1965

A. M. Hutter, M.D., Fond du Lac, Chairman
S. E. Sivertson, M.D., La Crosse
Walter C. Kleinpell, M.D., Kenosha
George M. Shinners, M.D., Green Bay
Patricia F. Lanier, M.D., Kewaunee
George G. Stebbins, M.D., Madison
E. P. Ludwig, M.D., Wausau
R. C. Cantwell, M.D., Shawano
Craig Larson, M.D., Milwaukee

During the past year the Division on Aging has given considerable attention to nursing home accreditation programs. It was recommended that the Division, as a representative body of the State Medical Society of Wisconsin, should not actively participate in the Wisconsin Commission on Accreditation, but that it should closely follow the activities of this commission.

The Division feels that a national program is preferable to the state standards set by different groups in each state, and the Council adopted the recommendation that the Society should endorse a program of uniform national accreditation standards.

At the present time, activities of the National Council for Accreditation of Nursing Homes of which the American Medical Association and the American Nursing Association are supporters have been endorsed.

The terminology used by the National Council for Accreditation of Nursing Homes is as follows:

1. Intensive Nursing Care Facility—Nursing service under the supervision of a full time Registered Professional Nurse, and a Registered Professional Nurse is on duty at all times.
2. Skilled Nursing Care Facility—Nursing service is under the supervision of a full time Registered Professional Nurse and a Professional Nurse or a Licensed Practical Nurse is on duty at all times.
3. Intermediate Care Facility—Nursing Service is under the supervision of a full time Registered Professional Nurse or a full time Licensed Practical Nurse. An attendant is on duty at all times; at night the attendant is awake and fully dressed.

The Division has also worked closely with the State Board of Health's new regulations for nursing homes, and has maintained liaison with the State Board of Health and the State Department of Public Welfare on enforcement of these regulations. The accompanying reprint of a newspaper article summarizes the policy that has been adopted in enforcing the revised standards for the 520 licensed nursing homes in Wisconsin.

It is important to note that the State Department of Public Welfare has taken the position that the county welfare department shall have an oral or written recommendation from the attending *physician* as a basis for authorizing nursing home care at the outset of the period of care to be authorized. The physician's recommendation is also to specify whether care should be in a skilled, limited or personal care nursing home. Your Division members feel that this provision is of utmost importance and will continue to watch the implementation of the proposed regulations.

The State Board of Health definitions for different types of nursing homes are as follows:

1. Home for skilled nursing care . . . means a nursing home which is staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and not in need of hospital care but who require skilled nursing care.
2. Skilled nursing care . . . is defined as nursing care provided under the supervision of a registered professional nurse and physician.
3. Home for limited nursing care . . . means a nursing home which is staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and are not in need of hospital care or skilled nursing care but are in need of limited nursing care.
4. Limited nursing care . . . is defined as nursing care provided under the supervision of a licensed trained practical nurse and physician.
5. Home for personal care . . . means a nursing home which is staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and are not in need of hospital care, skilled nursing care or limited nursing care but require personal care.

6. Personal care . . . shall mean the provision of room, board, laundry and other personal services such as assistance in dressing, bathing, eating and ambulation.

The medical aspects of nursing home operations are also under review by the Division and the recent changes brought about by the accreditation programs and new regulations of the State Board of Health are being prepared for publication in the WISCONSIN MEDICAL JOURNAL.

In addition to reviewing the work of the State Board of Health and the State Department of Public Welfare, the Division has been represented at the State Commission on Aging's meetings on this subject.

A meeting of this group in October was called to consider nursing home regulatory procedures and the functions of state regulatory agencies involved in setting standards in licensing and in inspection of nursing homes. Recommendations made during this and subsequent meetings will occupy much of the Division's time during the ensuing months. Also further investigation will be made of hospital-owned facilities versus independent nursing homes or chronic illness facilities with hospital affiliation.

The Division during the past year has also been interested in and aware of the coordinated home care programs that have developed in Wisconsin.

The Commission on Medical Care Plans at the request of the Division is investigating community-based and hospital-based programs and the Division continues the recommendation that it made a year ago, and which was adopted by the House of Delegates, that county medical societies cooperate in the development of ancillary services to coordinated home care programs.

Employment services for persons over 65 have also received the attention of Division members and it is recommended that a workshop be planned that is devoted exclusively to the problems of re-employment of older Americans.

FISCAL NOTE

A. Proposed one-day Conference on Problems of Re-Employment of those of Retirement Age

Estimated Budget

1. One out-of-state speaker, honorarium and expenses	$ 100.00	
2. Preliminary publicity, including circulation of program, providing for advance registration, printing and postage—approximately 500 on list	125.00	
3. Publicity at time of event, pictures and releases to various news media	50.00	
4. Travel expenses, in-state speakers	100.00	
5. After conference expense—preparation and circulation of summary, copies of talks and miscellaneous	$ 50.00	
6. Staff time—can be absorbed		
		$ 425.00

B. Proposed Conference on Medical Aspects of Nursing Home Care—This proposal has not been reviewed by the Division on Aging but the staff estimates the cost of the program will be much the same as the Conference on Re-Employment except that approximately 50 per cent will be recoverable in supportive funds

Estimated Budget

(net) $ 212.50

Reprinted from the MINNEAPOLIS TRIBUNE, Oct. 25, 1964

WISCONSIN TO 'GO EASY' ON NURSING LAW

By TRYGVE M. AGER
Minneopolis Tribune Wisconsin Correspondent

MADISON, Wis.—A spokesman for the State Board of Health says a "go easy" policy will be pursued in enforcing the revised standards for the 520 licensed nursing homes in Wisconsin.

Under the new standards the homes are licensed according to the degree of care provided: A home licensed for "skilled care" must have a registered nurse on duty at least 40 hours a week; one offering "limited care" must have a practical nurse, and one offering "personal care" only does not need to have a nurse.

Any home may lose its license by accepting or retaining patients whose need for care exceeds the level of care for which the home is licensed.

"However," says Alfred H. Hintz, public health engineer of the State Department of Health, "we are going to be very careful and reasonable about this. I understand the State Department of Public Welfare is also taking this very easy to begin with. After a year enforcement may stiffen."

Adoption of such a plan now was precipitated by the Health Assistance Payments Act, based on the federal Kerr–Mills Act, passed by the 1963 legislature.

Concern over possible effects of the new classifications has been expressed by county welfare board members and by State Department of Public Welfare functionaries in many parts of the state.

Recently a joint meeting of welfare boards of St. Croix, Polk, Dunn and Barron Counties adopted a resolution warning against "premature and precipitous enforcement" of the new rules.

One of the main apprehensions of county board members is that the regulations may force nursing homes to employ more trained personnel, thus stepping up the per-patient costs.

The four-county resolution mentioned above pointed out that "60 per cent of all patients in nursing homes are recipients of public assistance through county welfare departments."

Already some county boards are under pressure to increase per-patient payments because of the new Wisconsin minimum wage laws with which nursing homes are compelled to comply.

Welfare workers in the various counties are concerned with possible effects of strict enforcement of the new regulations on the patients themselves . . .

"Forcing a change of environment, such as the shift from a small personal care nursing home in a person's own community to a skilled care home in another town or even another county, could prove injurious to some older people," he continued.

The same director pointed out that through other regulations the State Department of Health has gradually eliminated "quite a number" of unsafe or otherwise undesirable nursing homes, and that the new regulations might have a similar effect.

■ REPORT OF DIVISION ON VISUAL AND HEARING DEFECTS of Commission on State Departments—May, 1965

Meyer S. Fax, M.D., Milwaukee, Chairman
James V. Balger, Jr., M.D., Waukesha
Richard J. Fagle, M.D., Racine
John B. Hitz, M.D., Milwaukee
Richard H. Bradhead, M.D., Wausau
Donald A. Peterson, M.D., Madison
W. B. Larkin, M.D., Eau Claire
George Nadeau, M.D., Green Bay
C. G. Reznichek, M.D., Madison

Activities of the Division on Visual and Hearing Defects during the past year have included a review of "Industrial Commission Rules for Determining Loss of Visual Efficiency" under the Wisconsin Workmen's Compensation Act, a review of the use of the title "Doctor" by non-physicians, and an interpretation of Chapter 507, Laws of 1964.

The Division has worked with the Industrial Commission on the rules for determining loss of visual efficiency, and with the approval of the Commission on State Departments and the Council of the Society, the following recommendations were made to the Chairman of the Industrial Commission.

It was recommended that the concept that medical men should be concerned with physical impairment, or visual impairment rather than with visual disability should be strongly emphasized to all those concerned in the procedures involving compensation awards. This includes the members of the Industrial Commission themselves, their staff, lawyers involved in compensation cases, and the medical profession. The Division further recommended that a method of periodically modifying the rules for determining loss of visual efficiency be worked out. The Division stated that it felt that the Industrial Commission should incorporate into its guide the American Medical Association's standards for the evaluation of loss of central vision.

It was also suggested to the Industrial Commission that a clinical research project be set up to study the comparison of the two types of binocular vision tests that are provided for in the American Medical Association's guide and the Industrial Commission's guide.

The Subcommittee on Visual Problems of the Division recommends that it continue to work with the Industrial Commission on these guides and that an attempt be made to set up the clinical research project on binocular vision during the coming year.

The Division also concerned itself with an interpretation of Chapter 507, Laws of 1964. This provision of the laws provides that "Any agency of the state, county, municipality or school district shall accept the optometric services, as defined in sub. (1) of optometrists licensed under this chapter, on the same basis as those of any other person authorized by law to render such services." The Committee feels that no agency of the state, county, municipality or school district can be compelled to accept the service of an optometrist, because only after competent medical evaluation can it be determined that the problem of a patient can be managed within the area covered by the limited license of optometry.

The position of the Division on Chapter 507 was transmitted to the Commission on State Departments and the Council with the recommendation that this interpretation be made available to all county health personnel and school health officials. This recommendation received Council endorsement.

The Division has also been interested in legislation affecting eye care and has worked with the Society's Advisory Committee on Ophthalmology in forming legislative policy for consideration by the Commission on Public Policy. The report of the Commission on Public Policy to the House of Delegates contains information on this type of legislation.

The Division during the past year has dealt with many problems affecting the profession and in the months ahead a series of one-day courses on Hearing Conservation in Industry will be planned, along with training courses for audiometric technicians, as approved by the House last May.

FISCAL NOTE
No unusual expenses not previously budgeted.

■ REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES of Commission on State Departments—May, 1965

Charles A. Wunsch, M.D., Green Bay, Chairman
Edward E. Haufek, M.D., Shebaygan
J. T. Petersik, M.D., Oshkash
G. B. Tybring, M.D., Madisan
Henry Veit, M.D., Milwaukee
Jean P. Davis, M.D., Milwaukee
Keith M. Keane, M.D., Appletan
A. A. Larenz, M.D., Eau Claire
T. J. Nereim, M.D., Madisan
Otta A. Dittmer, M.D., Ripan
Francis M. Farster, M.D., Madisan
William H. Heywaad, M.D., Marshfield
Walter J. Urben, M.D., Madison

During the six months since last reporting to the Commission on State Departments, the Division on Nervous and Mental Diseases has been involved in discussion in many areas of the care of the mentally ill and some of the numerous ancillary areas involved in such care. The Division has also started to attempt to assess and to invite assessing as to just what is its useful role in the State Medical Society of Wisconsin. It feels warranted concern lest its meetings, often with content pressing and urgent in quality, attenuate into group therapy for Division members or become so delayed in transmission through State Medical Society "channels" that deliberation becomes pointless. To clarify this comment, the Division adds the fact that it clearly realizes that it exists as a segment of a structure in a large medical society composed of generalists and of many specialties; it does not seek voice to which it is not entitled. The Division also recognizes, however, the same fact emphasized in its report of one year ago; beds for mental patients still comprise half the hospital beds in this state; care of patients with psychiatric problems still comprises from 30 to 50 per cent of the practice of *non*-psychiatrist physicians; development of patterns of relationship with government sponsored care of many levels of mentally ill people is still the primary health problem not worked out in the USA by physicians.

These issues concern almost *all* members of the State Medical Society of Wisconsin and patterns of utilization of services in mental care may well set paths of demonstration for care in other fields as well. In brief, at any national level meeting Division representatives have attended, the point has been clearly made that unless private medicine provides ways of care for all who need it rather than only for those who can afford it, government controlled care of the mentally ill becomes increasingly necessary. One year ago and now we still, as private physicians, have ways open to us to relate on some form of fee for service basis, without losing our private practice posture, in providing services locally through use of state supported structures

that necessarily provide care for a significant segment of the population of the psychiatric patients. If we do this, we not only provide services; we provide, by action, patterns which meet local need under primarily local directive auspices.

The Division again disavows a statement attributed to it in its final report, as published in the WISCONSIN MEDICAL JOURNAL in December, 1964, pertaining to clinical psychology and stating: "There is no reason to doubt the efficacy of the Medical Practice Act in preventing the unlawful practice of medicine and flagrant violators can and will be stopped."

The Division did not make this statement and specifically disavowed it in the minutes of its meeting of September 27, 1964. This statement grossly underestimates the issue. The problem is not one of stopping some and blessing others. The problem is a much larger one of a necessary development of relationship between many large groups of professional and semi-professional people, all of whom are component in the care of the mentally ill; it is a much broader issue than psychology alone. The issue is not one of stopping the occasional flagrant violator, which may indeed be necessary at times, but rather the issue is one of construction of useful and mutually acceptable relationship and self-limitation between a number of ethical and useful professions. We are in an age of federal, state and local, private and public, emphasis on the development of care in the field of psychiatry. It is strikingly important that medicine as a whole, and not only psychiatry as a specialty, remain energetically at the core of these developments and patterns of relationship.

In more specific terms, we are at present in a period of time in which federal law has made allocations for construction of "Community Mental Health Centers." It is reasonably anticipated that money for staffing these centers, when they are built, may well be allocated in the near future at a federal level of government. The Wisconsin State Department of Public Welfare has created the "Comprehensive Mental Health Planning Committee of the State of Wisconsin," which includes a central, many district and very many county level committees as well as task forces, each made up entirely or primarily of non-public official representatives. The Division, through the State Medical Society representative on the central committee, follows this planning closely. Also, many psychiatrists and physicians serve on district or county level committees. The Division believes that the State Medical Society is not as yet cogently enough aware of the importance of physicians being individually involved in these developments in their locale.

The Division remains in active communication with the State of Wisconsin Mental Health Advisory Committee, whose physician member is regularly invited to Division meetings. This committee is currently considering proposing to the Legislature a revision of the Mental Health Act (Chapter 51). We do not find the State Medical Society invited to formal participation in such planning of a revision, except as one of several agencies mentioned as having consultative value. Yet, the manner of admission of a patient to state or county hospitals, the manner of operation of guidance clinics or day care centers or out-patient services, the criteria of commitment, the commitment of alcoholics or drug addicts—all of these seem to the Division to constitute fundamentally medical matters.

The budgetary request of the Division of Mental Hygiene, in regard to guidance clinics, went from $1,465,049 in the last biennium to $2,046,602 for the next biennium. We ask in what manner do physicians plan to participate in this useful and large movement in mental care?

With regard to the preceding paragraphs, the Division must state flatly that a scattering of single interested physicians through the state is not enough to maintain medical standards of care in these many developments. These are good developments, but they are only at their best when the private physicians of the given area are actively and energetically involved in the function of the unit, be it county hospital, guidance clinic or day care. We believe this area calls for formal involvement of the State Medical Society as a whole.

In another area, in accord with directives of the State Medical Society Council, the Division attempted postgraduate education of physicians. Funds were obtained from drug companies (Geigy Laboratories, Merck Sharp and Dohme Postgraduate Program, Roche Laboratories, and Smith Kline and French Laboratories), through Mr. Roy Ragatz. Program development was in cooperative effort with the American Academy of General Practice. Programs were proposed as one-day sessions in five areas of the state; La Crosse, Fond du Lac and Wausau general practice societies indicated no interest or refusal; Green Bay and Sheboygan accepted. Budget was about $400.00 per meeting. Postgraduate credits were arranged through AAGP. A University speaker, a local speaker and panels were arranged for each session. Excellent advance advertising was provided through State Medical Society mailings to the two areas, each of eight counties. Twenty-one (21) physicians registered at Sheboygan and thirty-one (31) at Green Bay. The Division voted to try again next year through principle rather than gratification.

Under Council directive the Division is at present exploring, with some misgiving, the idea of postgraduate education and treatment implementation of alcoholism in local communities.

On a more positive note the Division recognizes with commendation the Postgraduate Education Programs of the Northwest Psychiatric Clinic at Eau Claire where one-day teaching programs have attracted about 200 physicians annually. The programs are most excellently prepared, with speakers of national and international significance. Pursuant to this has been a good deal of Division discussion as to just what is and what should be the role of the State Medical Society in postgraduate education; what does the State Medical Society approve; where will the State Medical Society give its seal or Charitable, Educational and Scientific Foundation logo-type as program indication of approval; is the future State Medical Society role to originate programs or also to give its approval to programs originating elsewhere and to set standards for programs. In an expanding population these seem to be important questions. Through these discussions a statement of formal approval by the State Medical Society was received for the Eau Claire program. The future role of the State Medical Society is still a potent question in postgraduate education.

The Division endorsed and recommended State Medical Society approval for the Postgraduate Programs in Psychiatry currently being prepared through the Wisconsin Psychiatric Institute under aegis of Ben Glover, M.D. These programs are financed by an NIMH grant and promise to be of much use to interested physicians in trial local areas.

The Division is in process of preparation of a survey of the practices and professional activities of private psychiatrists. The Division believes in public care for those who need it, but also is convinced that the cost of private methods of care is substantially demonstrably less costly and more efficient. These views relate closely to the above mentioned emphasis on the importance of private

physicians maintaining a position in the care of the public patient in psychiatry. We hope to be able to use the results of this study for presenting the position of the Division to the Council of the State Medical Society, and also for fostering a corrected public image of the psychiatrist and giving information regarding private care to the Comprehensive Mental Health Planning Committee. We believe private care is now reaching over half of the mental patients in this State of Wisconsin, and possibly more by public resources utilizing private physicians on a fee for service basis.

Bill 389, S. would allow welfare departments to pay private psychiatrists hospitalizing a welfare patient in a psychiatric ward in a private hospital, just as is the custom in organic illness. This bill is not yet passed or re-introduced and the Division recommends active pushing of this bill by the State Medical Society.

The mode of relationship of private physicians to guidance clinics and also county hospitals is still being studied. While no formalized recommendation is as yet made by the Division, it yet is apparent that in actual practice the most effectively used relationship seems to be a fee for service relationship of these clinics and hospitals with private physicians in the community. This relationship tends gradually to keep the public service structure in the main stream of community medicine, to reduce its isolation and even its stigma and in turn to extend the private physician into an area of public need where he ought to be. However, it is doubtful that any recommendation could ever be made to apply universally to the many variables of community size, geographical location and special individual circumstances.

An annual announcement regarding the addictive dangers of some of the newer synthetic drugs used with psychiatric patients is planned by the Division for publication in the WISCONSIN MEDICAL JOURNAL. One such announcement is thus far published.

The Division is currently studying a movement toward self-certification developing within the Wisconsin Psychological Association. We have appreciated the cooperation of the leaders of this Association in discussing their plans with us, as obviously the State Medical Society has nothing to say about what the Wisconsin Psychological Association does within itself. The concept of self-certification had been recommended to the Wisconsin Psychological Association several years ago, both before and after its attempt for legislative certification failed passage in the Senate (Bill 77, S.). We hope to be able to recommend a position to the State Medical Society soon in regard to this matter.

The American Medical Association Second National Congress on Mental Illness and Health, held in Chicago in November, 1964, was well attended by Division members, with one member conducting a workshop and several members serving as panelists. The content of the Congress seemed to us to emphasize that the methods of relationship between private physicians and public structures that is thus far developed in Wisconsin is indeed the right pattern, and although Wisconsin has a long road yet to travel in development the state is well ahead of many other states in the use of these concepts. More formalized State Medical Society involvement in these areas might well encourage more energetic involvement of individual physicians at local levels.

The Division voted unanimously to prohibit publication of its minutes prior to the minutes having been approved by the Commission on State Departments, the State Medical Society Council and the House of Delegates of the State Medical Society. Until such clearance the minutes are not finalized and the Division believes that premature publication, especially if out of context, may simply create furor without cause in some instances.

Out of discussion through the past year or more regarding the above many matters, and out of a recognition of the stormy adolescence of development in which many of the above matters of mental care now have their being, the Division has come to some firmed up conclusions about itself which it now wishes to pass on to its parent bodies in the State Medical Society:

a. The Division believes, without qualification, that the problem of the patterns of care and utilization of professional services for the many varieties and degrees and shadings of the so-called "mentally ill" is the largest health problem in Wisconsin and in the USA today, surpassing in importance even "Medicare for the Elderly" in regard to cogent present issues and future implications.

b. The Division does not believe it is as yet getting through to the State Medical Society Council, House of Delegates and membership a sufficient depth of realization of the magnitude of these issues and the importance of local physician participation in the core of care of the mentally ill at present and in the core of planning for the future. Many ancillary professions need to be component in the proper care of the mentally ill; none of them, physician and psychiatrist included, can do it in part or whole alone but the field by its nature lends itself to the foggy view that anybody with a warm interest in people is equipped to counsel.

c. The Division does not believe that the State Medical Society is as yet fully enough represented in the many planning meetings that take place and in the assessing of new laws proposed at the time rather than find our views coming out "through State Medical Society channels" two or six months after a law is passed or defeated. The bulk of the care of the "mentally ill" in this state is by physicians, but the State Medical Society as a formal body of physicians is not staffed enough to make itself heard and have its views sought in pre-legislative planning discussions to the degree we feel indicated.

d. Presentation to the State Medical Society Council and House is slowed down by Division status in a Commission and State Medical Society channels.

Because of these facts the Division recommends the following:

a. We find no quarrel with the well run Commission on State Departments but we believe we become slowed down by having to clear through the Commission. For facility of transmission of view to the Council and House and membership we believe the Division should, for the current years at least, become a Commission of the State Medical Society to try to deal more effectively with the extremely large mental care issue. Another alternative would be for the State Medical Society to establish instead a Council on Mental Illness and Health, much as the American Medical Association did ten years ago.

b. In line with the above, and regardless of whether the unit for Nervous and Mental Diseases were a Division, a Commission or a Council, we recommend that the State Medical Society allocate funds for a full time staff man

in this field, plus allocation for sufficient secretarial services and travel expenses.

NOTE BY THE SECRETARY'S OFFICE: The Council directed that the report be forwarded to the House in the form submitted by the Division. However, the Council wishes to advise the House that it does not believe it advisable to provide special financing for activities of any Division.

FISCAL NOTE

A. Postgraduate Education Programs on Psychiatry and General Practice estimated at $500.00 per program. The Division anticipates three programs for a total cost of $1,500.00. A portion of the expense is recoverable in supportive funds.

Estimated Budget

1. Speakers honorarium and expenses	$ 200.00	
2. Preliminary publicity, including circulation of program, providing for advance registration, printing and postage	120.00	
3. Conference dinners	125.00	
4. Staff travel	25.00	
5. Staff time can be absorbed		
6. Miscellaneous	30.00	
Per Program		$ 500.00
Total		$1,500.00

B. Staffing provisions requested by the Division

Estimated Budget

1. Full-time employee (salary range $6,000.00 to $7,500.00)	$7,500.00	
2. Secretarial service (½ full-time employee)	2,500.00	
3. Employee benefits (insurance programs, Workmen's Compensation, office equipment, depreciation on equipment, etc.	2,000.00	
4. Travel expenses for staff	750.00	
5. Postage and Machine Service expenses	800.00	
		$13,550.00

REPORT OF DIVISION ON MATERNAL AND CHILD WELFARE of Commission on State Departments—May, 1965

John R. Evrard, M.D., Milwaukee, Chairman
F. G. Johnson, M.D., Superior
Merlin J. Olson, M.D., Monroe
Kenneth F. Pelant, M.D., Grafton
George H. Stevens, M.D., Wausau
Richard C. Brown, M.D., Eau Claire
William R. Kreul, M.D., Racine
T. A. Leonard, M.D., Middleton
B. P. Waldkirch, M.D., De Pere
E. A. Birge, M.D., Milwaukee
Stewart L. Griggs, M.D., Green Bay
K. J. Winters, M.D., Wauwatosa

Several matters of importance have been discussed by this Division since last reporting to the House in October, 1964.

1. Statement on Nurse Responsibility

At the suggestion of the Maternal Mortality Study Committee the Division has undertaken a study of nurse responsibility in the area of obstetrics and gynecology. This study has been made in recognition of the fact that with changed modes of practice, and hospitalization of most pregnant women, there are many procedures which heretofore have been designated as "medical practice" which are now commonly being performed by nurses, generally, but not always, upon the immediate direction of a physician.

A special *ad hoc* committee was appointed with approval of the Council representing obstetricians and pediatricians, hospital administrators, representatives from the Bureau of Maternal and Child Health, State Board of Health and various branches of nursing directly associated with obstetrical care in hospitals.

The report of this committee has been approved by the Council, and is presented to the House of Delegates for official action.

It is important to note, in evaluating this report, that it is not in any sense a directive. It is rather in the form of recommendations made to local hospital groups, to implement in terms of local resources, with primary regard for the welfare of the patient. The Division feels that this report is worthy of study by all hospital, medical and nursing staffs, and urges that current procedures in care of the obstetrical and pediatric patient be reviewed, in relation to the recommendations set forth in the report included with this summary of Division activities. (This report appeared in the July issue of the WISCONSIN MEDICAL JOURNAL at page 262.)

2. Tapes on Maternal Mortality

The Maternal Mortality Study Committee has prepared a series of instructional tapes on six subjects related to maternal demise. These topics were selected on the basis of actual cases reviewed, which indicate the need for more physician education on the subjects discussed by members of the Maternal Mortality Study Committee. The tapes now available through the Bureau of Maternal and Child Health of the State Board of Health are:

a. *Amniotic Fluid Embolism*
b. *Shock in Intra-Partum and Immediate Post-Partum Period*
c. *The Latest on Toxemias of Pregnancy*
d. *Proper Management of the RH Sensitized Pregnant Woman*
e. *Appendicitis in Pregnancy*
f. *Preferred Types of Anesthesia for Various Types of Delivery and Complications of Pregnancy*

Physicians are urged to secure these tapes for individual and group study. (Announcement concerning these tapes appeared in the June issue of the WISCONSIN MEDICAL JOURNAL at page 220.)

3. Identification of the Newborn

The attention of the Division has been directed to the varying, and often questionable, methods employed in hospitals for the identification of the newborn. The Division has gathered information on this subject, and has sent recommendations to medical staffs of Wisconsin hospitals so the best possible methods can be employed to forestall situations in which alleged exchange of babies in the hospital takes place. While this situation does not frequently occur, when it does it results in an emotional situation which all physicians and hospitals wish to avoid if at all possible. (Announcement of this information appeared in the March issue of the WISCONSIN MEDICAL JOURNAL at page 124.)

4. Mandatory Phenylketonuria (PKU) Testing

The Division is aware of increased interest by many groups of enacting legislation which would make PKU testing (and reporting) mandatory. The Division reviewed this subject and originally recommended that legislation of this character be opposed. It was felt by the Division that currently the

tests are not conclusive, and that the resulting laboratory work of mandatory testing of all newborn would result in costly and non-uniform testing in local hospitals.

Since originally considered by the Division specific legislation on this subject has been introduced in the Wisconsin Legislature, which would provide funds for testing, and a plan to have such testing done in hospital laboratories approved by the State Board of Health. While the Division still feels it undesirable to legislate compulsory testing on a small segment of medical practice it recognizes that the objectives of the case finding cannot be achieved by partial testing, and the public demand for such a program may well result in legislation which the State Society should not oppose.

5. The Abused Child

The Division is aware of national publicity directed to this subject, and consideration is being given to a change in the Wisconsin Statutes as to reporting, so physicians will be encouraged to report cases of suspicion to social agencies, for investigation, rather than to law enforcement officers, with resulting legal action automatically directed to parents. The current law is also being studied, to make sure that reporting physicians will be entirely free from threat of legal action.

The Division is pleased to report that physicians throughout the state have cooperated wholeheartedly with the Maternal Mortality Survey, and this continues to be a valuable avenue for research and physician education. It is hoped that hospital staffs will give serious thought to recommendations of the Division on nurse responsibilities and identification of the newborn. Division members are appreciative of the cooperation of Doctor Wardlaw and his staff in the Bureau of Maternal and Child Health of the State Board of Health in providing the Division with assistance and data on the many subjects discussed this past year.

FISCAL NOTE

A. Distribution of "Statement on Nurse Responsibility" to medical staffs
Estimated Budget
1. Printing and postage ---------- $50.00

B. Publication of "Statement on Nurse Responsibility" in the WISCONSIN MEDICAL JOURNAL
Estimated Budget
1. Publication in WISCONSIN MEDICAL JOURNAL $50.00

C. Publication in the WISCONSIN MEDICAL JOURNAL concerning availability of tapes prepared by the Division
Estimated Budget
1. Publication in WISCONSIN MEDICAL JOURNAL $25.00

■ REPORT OF DIVISION ON CHEST DISEASES of Commission on State Departments —May, 1965

H. A. Anderson, M.D., Stevens Point, Chairman
B. R. Lawton, M.D., Marshfield
William J. Little, M.D., Racine
Richard H. Wasserburger, M.D., Madison
John Rankin, M.D., Madison
John H. Huston, M.D., Milwaukee
Louis G. Nezworski, M.D., Eau Claire
George C. Owen, M.D., Milwaukee
Warren K. Simmons, M.D., Rhinelander
John H. Wishart, M.D., Eau Claire

Since last reporting to the House in October 1964, the Division has given further consideration to Resolution 25, presented at the May 1964, session, in which Waupaca County asked that the State Board of Health be required to change its reporting form sent those examined at mobile units to indicate that the follow-up examination would be conducted by a private physician, and that a charge for this service would be made. After consulting with the State Health Officer and members of his staff, the Division is convinced that there is no basic problem with the procedures now being followed, and recommends that the House table Resolution 25, presented at the May 1964 session and referred to the Council for further action.

In making this recommendation it might be pointed out that the Division sought an evaluation of the problem by Waupaca County officers, and no evidence was given to indicate that this was more than an isolated complaint. No one appeared in favor of the Resolution when it was presented in 1964, which would further indicate that the problem was not of sufficient magnitude to suggest a change in reporting. The Division was further informed that a statement such as suggested in Resolution 25 (1964) would not be correct, inasmuch as in many instances follow-up is *not* paid for, when the person is on relief, or when given as an out-patient service of a sanatorium.

Hypertension Program

This continues to be a valuable service of the mobile unit screening program of the State Board of Health, and is being widely used throughout the state. It is only conducted with the approval of the county medical society. It has been reported to the Division that 53 of the 72 counties in the state have also utilized the diabetic services of the screening program, and some meaningful findings have resulted from this additional service.

There is still some objection to what physicians feel is "over referral" of cases which suggest cardiac conditions being evaluated by the private physician. To meet this criticism the State Board of Health is suggesting restricting referrals to those whose blood pressure exceeds 180 systolic and for cases over 100 diastolic. Plans are to report findings on these cases to the physician, and he can determine (when the patient calls) if he feels the person should be seen for further study. The Division has requested the State Board of Health to relate age to referrals, to determine if there is some age above which even the higher pressures or certain cardiac changes would not be referred for possible further study by the family physician.

Hospital Admission X-Rays

The Division has for many years advocated routine x-rays for all hospital admissions, not only as a protection of nurses and other hospital personnel against unsuspected tuberculosis, but also as a means of detecting other abnormal chest findings. Initially these programs employed the miniature film, but the use of this has many disadvantages, and a larger film is now advocated. A number of Wisconsin hospitals are employing the use of larger films, with reduced charges made to patients for this service. The Division advocates that all hospitals not now providing this as a routine admission service consider it as an extension of their hospital program.

TB Testing of School Children

While criteria on school testing programs have been published in the past many schools are not aware of the test recommended, and what procedures are to be followed. These criteria have been developed by the Division in cooperation with the

State Board of Health, and any physician asked to assist with local testing programs is urged to secure the current recommendations from the State Board of Health. At the present time the recommended testing material is Intermediate Strength (5 TU), PPD, intradermally administered. Nurses, if properly instructed by physicians, are qualified to administer the test, but the criteria for referral should be set by a medical advisory committee of local M.D.'s.

The Division on Chest Diseases remains in close touch with the programs of the State Board of Health and WATA, and will report to the House any significant developments in programs conducted by these agencies.

FISCAL NOTE

No unusual expenses not previously budgeted

■ REPORT OF DIVISION ON HANDICAPPED CHILDREN of Commission on State Departments—May, 1965

J. W. Nellen, M.D., Green Boy, Choirman
Robin Allin, M.D., Modison
Roy R. Rueckert, M.D., Portoge
Lloyd P. Willioms, M.D., Appleton
F. D. Bernard, M.D., Modison
John J. Suits, M.D., Morshfield
George H. Hondy, M.D., Wisconsin Ropids
Jomes E. Miller, M.D., Modison

The last report of this Division, presented at the October 1964, meeting of the House of Delegates, outlined in general terms the current programs of the Bureau for Handicapped Children, and indicated that the Bureau planned to expand into new fields of endeavor where it was felt services might be of value to citizens confronted with financial need as a result of unusual medical costs associated with illnesses of children within the scope of activity of the Bureau.

Since then the Bureau has reviewed with the Division a pilot program of assistance in the area of cystic fibrosis, and a proposed extension of services (within limits of resources available) for specific congenital anomalies. The Division has assisted the Medical Director of the Bureau in setting up criteria which will qualify an individual family for assistance, and it is important to emphasize that this program, as all other programs of the Bureau is dependent upon certification of financial need, and is restricted to cases in which the family physician suggests to the Bureau that the patient be extended assistance if the qualifications for assistance are met. (Announcement of this new medical care program appeared in the April issue of the WISCONSIN MEDICAL JOURNAL at page 167.

The Division learned with regret that the Medical Director of the Bureau, Patricia McIllece, M.D., is resigning to take special training in child psychiatry, but the Division members have assisted the Director of the Bureau in setting up qualifications to assure the continuance of medical direction which the Bureau has enjoyed under the direction of Doctors Tenney and McIllece for so many years.

The Division is pleased to report that all programs of the Bureau for Handicapped Children are being conducted with full regard for the close relationship of the Bureau with the family physician, and the restriction of assistance to cases which are suggested for service by the family doctor, and are certified as to financial need.

FISCAL NOTE

No unusual expenses not previously budgeted

■ REPORT OF DIVISION ON SAFE TRANSPORTATION of Commission on State Departments—May, 1965

Richord B. Windsor, M.D., Sheboygon, Choirmon
George Anderson, M.D., Stevens Point
Arch E. Cowle, M.D., Modison
E. E. Eckstom, M.D., Monroe
Jomes L. Weygondt, M.D., Sheboygon Folls
Frederick Bunkfeldt, Jr., M.D., Milwoukee
Wolter F. Smejkol, M.D., Monitowoc
Richord C. Wixson, M.D., Modison

The physician's role in traffic safety—to lend his special knowledge to help reduce injury and death on our highways—assumes added importance each year as the traffic toll mounts.

Medical Limitations on Driver Licensing

The Division has initiated a study into the procedures for issuing and renewing drivers' licenses, a complex subject which will require detailed analysis of the medical aspects involved. Its discussions to this point have resulted in recommendations that the Society:

1. Take steps to initiate or encourage legislation to make all drivers' license renewals be on the basis of personal appearance before a representative of the State Motor Vehicle Department.
2. Recommend to the Motor Vehicle Department, and encourage necessary legislation, to broaden the functions of the Epilepsy Review Board to that of a Medical Advisory Committee which would consider all areas of medical limitation for driver licensing.
3. Ask the Motor Vehicle Department to develop a procedure whereby any reports concerning physical examinations be accompanied by a release of information to be signed by the applicant and retained in the physician's record.

The Division will continue detailed study of the entire subject of medical aspects of driver licensure, with special attention to the problems of licensing older drivers.

Proposed Legislation

Four legislative proposals dealing with medical aspects of traffic safety were reviewed in detail by the Division and recommendations that the Society support enactment of them were forwarded to the Commission on Public Policy. The bills considered were 65, A., 81, A., 87, A. and 97, A. dealing with "implied consent" for chemical tests for intoxication and related issues.

Depth Perception in Driving

The Motor Vehicle Department requested the Division's recommendation concerning criteria for depth perception for candidates for the Wisconsin State Patrol. After study of current medical literature and present policies of licensing bodies, the Division advised that it would be a rare occurrence for an applicant to have good visual acuity and poor depth perception, and if a problem became evident the individual candidate should be retested in all areas of visual acuity.

Motor Vehicle Design

Of the three factors in safe transportation—driver, vehicle and environment—the least attention is being given to providing a safe vehicle. Recent federal legislation provides a "guide" in this

area by setting standards for passenger motor vehicles purchased by the federal government. The Division feels this would be a commendable action on the state level and recommends:

1. The Society initiate action to require the individual or department responsible for purchasing passenger motor vehicles for the State of Wisconsin to adopt the standards for passenger safety devices as established by the Federal Administrator of General Services under Public Law 88–515.

Emergency Transportation of the Ill and Injured

Emergency transportation of the ill and injured, with development of a high standard of equipment and personnel in Wisconsin, continues to be a concern to the Division. Its recent guide on this subject has been widely distributed in the state and there are indications that it has initiated interest and discussion on the part of organizations and public officials concerned with providing these services.

Automobile Visibility as a Factor in Auto Safety

Discussions were held with the Wisconsin State Chamber of Commerce concerning auto visibility as a safety factor, and particularly the value of auxiliary running lights for daytime use. The Division will continue investigation concerning the medical aspects of this topic.

FISCAL NOTE
No unusual expenses not previously budgeted

■ REPORT OF DIVISION ON SCHOOL HEALTH of Commission on State Departments —May, 1965

James C. H. Russell, M.D., Fort Atkinson, Chairman
E. E. Bertolaet, M.D., West Allis
R. F. Poser, M.D, Columbus
F. W. Reichardt, M.D., Stevens Point
Horace K. Tenney, III, M.D., Madison
William T. Brodhead, M.D., Madison
Frances A. Cline, M.D., Rhinelander

The Division feels that the most constructive effort to accomplish its short and long range goals in school health lies in more effective communications between physicians and educators. For this reason, it is undertaking a series of projects to communicate Society policy to local educators and physicians, and will continue in the coming year to give major attention to improved communications. Specific projects, approved by the Council, are:

1. Distribution of an American Medical Association statement on "Exercise and Fitness" to educators in the state.
2. Mailing of sample forms to be used in reporting the pertinent information from medical examinations of students back to the schools, with the recommendation that these forms be adopted for standard use. This form has previously been approved by the House of Delegates and has now been tested in selected school systems.
3. Preparation and distribution of a pamphlet to educators and county medical societies detailing present policy of the State Medical Society in the area of school health, and particularly physical fitness.
4. A statement to presidents of teacher preparation institutions dealing with teacher preparation in the field of health education.
5. Providing subscriptions to "Today's Health" to health education students at the University of Wisconsin as a method of keeping them informed on current health topics.

Cooperation With Agencies and Organizations

The Division acts in an advisory capacity to the State Department of Public Instruction, the State Board of Health, the State Board of Vocational and Adult Education, and the Wisconsin Interscholastic Athletic Association. In this connection, two specific developments are reported:

1. In cooperation with the WIAA, the Division developed a guide on "Athletic Disqualification—Junior and Senior High School Level," to assist physicians in making these determinations. (The guide was published in the January issue of the WISCONSIN MEDICAL JOURNAL at page 28.)
2. Physician speakers participated in six regional conferences on "Sports for Girls" which were sponsored by the State Department of Public Instruction.

The Division wishes to inform the House of Delegates of the death in January of this year of Mr. Orlo R. Miller, who served for many years as representative of the State Department of Public Instruction to the Division. Mr. Miller's contributions in the field of school health, and particularly in the area of physical fitness, have been of great value to physicians of Wisconsin and the school children in our state.

FISCAL NOTE
No unusual expenses not previously budgeted

■ REPORT OF COMMISSION ON MEDICAL CARE PLANS—May, 1965

E. M. Dessloch, M.D., Prairie du Chien, Chairman
Robert Krohn, M.D., Black River Falls, Vice-Chairman
R. S. Baldwin, M.D., Marshfield
Charles Benkendorf, M.D., Green Bay
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D, Milton
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
D. A. Jeffries, M.D., Shawano
P. B. Mason, M.D, Sheboygan
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
J. T. Sprague, M.D., Madison
A. H. Stahmer, M.D., Wausau
F. H. Wolf, M.D., La Crosse
W. P. Curran, M.D., Antigo, President
J. H. Houghton, M.D., Wisconsin Dells, President-elect

All members will receive with the April issue of the JOURNAL a printed 1964 WPS Progress Report which provides a summary of highlights of operations during the past year. Your attention is called to the following additional CMCP activities during 1964.

Medicare Negotiations

The medical care plan for dependents of men in the armed forces has been an active and time consuming project of the CMCP. During the year 1964 the question of the level of physicians' fees payable under this program has been discussed on almost a

continuing basis. The Office for Dependents' Medical Care has requested a general reduction in fees and has to date denied a request for an increase in the maximum schedule of allowances to enable Wisconsin to continue to reimburse physicians for their "customary, usual and reasonable" charges. Negotiations continue—the present contract has been extended periodically during the year with a present expiration date of May 31, 1965.

The CMCP has taken and intends to continue the position that a fee schedule applicable to Blue Shield contracts at a fixed income level is inconsistent with the concept negotiated by Wisconsin with the Federal Government. The Directive of HEW implementing Public Law 569 of the 84th Congress called for payment of physicians' services based on fees applicable to a local area "negotiated with the physicians representatives." It is the position of the CMCP that to submit to the demands of the ODMC for a change in concept would be a step backward. "Customary, usual and reasonable" fees were negotiated originally—there is no justification for a change in this concept.

Veterans Administration Contract

The CMCP filed notice with the VA that at the expiration of the present contract (July 1965) it was intended that Wisconsin renew only on the basis of a program of physicians' "customary, usual and reasonable" fees.

To date the Veterans Administration has not indicated its acceptance of this request. It is the intent of the CMCP to renew on this basis in 1965 and failing that to continue to negotiate the present contract until an acceptable improvement is obtained.

Kerr-Mills

The commission has attempted to follow closely the progress of the Kerr-Mills program in Wisconsin and to assist physicians by handling any inquiries about results of administration by the State Department of Public Welfare. In the early stages of the program it was found that confusion existed on the part of physicians, recipients of care, as well as employees of local welfare offices as to the benefits of the program and their administration. Many of these difficulties have been ironed out but some remain.

By direction the Commission is to act on behalf of the profession to help assure administration of Kerr-Mills consistent with the intent of the legislation adopted. Several bills presently pending before the Legislature are designed to improve the program. The final outcome of the proposed changes has not been concluded at this time.

Coverage Upgraded

As has been emphasized in prior reports, there has been a constant effort to upgrade outstanding contracts to a level more consistent with today's health care needs. This effort continued in 1964. A substantial number of contracts were upgraded from "A" and "B" schedules to Special Service, "customary, usual and reasonable" fees. At the present time in excess of 90,000 contracts outstanding provide for payment of fees on this basis.

Other insurers, including Blue Plans, are beginning to consider this approach to physicians' charges "invented" by WPS in 1955.

Century Plan Coverage

In 1964 a program for implementation in early 1965 was developed to provide for the enrollment of additional subscribers in the "65 and over" age category on increased CP benefits. At the same time existing subscribers numbering 15,000 were offered the opportunity to upgrade up the new benefits.

New Century Plan contracts issued after May 1, 1965, will contain a non-duplication clause. This limits benefits to the contractholder to the total amount of the expense he incurred. It is intended to discourage purchase of a number of contracts for the purpose of recovering a "profit" at the time of illness.

The national legislation now under consideration could have an impact on the number of WPS subscribers "65 and over" as well as the type of coverage they desire. Because of the uncertainty of the type of federal program that may be adopted, it is impossible to forecast its effect on WPS programs.

Growth Pattern

Earned premiums of $15,359,000 in 1964 represent an increase of $2,120,000 over the prior year.

As the Progress Report indicates, the continuance of such prestige groups as State of Wisconsin Employees, American Motors, and General Motors is a satisfying testimony to the confidence of the buyer in WPS concepts.

While other insurers are, for the most part, comparatively hesitant to expand their growth in the area of major medical benefits, WPS feels there is a need for expansion in this area of service. Major medical contracts in effect in 1964 increased by 8,129. Present major medical contracts in effect total in excess of 36,000.

Increased enrollment of those unable to remit through employed locations (non-group) can be accomplished. The non-group market needs upgrading of benefits presently available to them through other insurers. Out-of-date surgical-medical contracts which leave the buyer with a large balance to pay present a market for the expansion of WPS' programs.

Claim Payments

The payment of nearly $14,000,000 in benefits to subscribers in 1964 was an increase of more than $2,300,000 over the preceding year. This represents a return to the subscriber in the form of benefits of almost 90 cents out of each premium dollar paid to WPS. The net addition to reserves after payment of claims and administrative expense of approximately $73,000 is a creditable record of service to subscribers.

Reorganization

In the last half of 1964 a substantial amount of staff time was spent on the reorganization of departments as well as the implementation of existing programs. The position of a full time Insurance Director was filled in 1964. A Sales Director was appointed to coordinate the activities of the entire department in place of the previous system under which two directors were involved, one in the non-group and the other in the group sales field.

Additional systems of claims administration were developed on an experimental basis on Workmen's Compensation cases, services rendered during contract waiting periods, and the like. These systems were designed to result in claims savings which can subsequently be passed along to the subscriber in new benefit areas.

Rating and other underwriting techniques consistent with recent developments in the insurance field were adopted and implemented to keep the WPS underwriting approach "modern" and consistent with current market changes.

The installation of the IBM computer system was completed in 1964. Billing records, claims data and coverage statistics are maintained through this computer device. Additional mechanization in claims work and rate control will be adapted to the computer in 1965. This mechanization should result in additional savings which can be passed along to the subscriber in the future.

The results accomplished to date demonstrate the soundness of these changes.

Financial Status

Attached is a condensed Balance Sheet and Statement of Income and Expense for the year 1964.

Summary

The Commission on Medical Care Plans invites the suggestions and assistance of the medical profession in Wisconsin designed toward the betterment of WPS programs. Your Commission feels that the year 1964 was one of substantial progress in providing better insurance programs to the people of Wisconsin and encouraging similar progress by others in the health insurance field. WPS is in sound financial condition, is capably managed, and actively engaged in the improvement of existing and the development of new programs.

WPS exists to encourage the availability of better insurance to Wisconsin citizens. This goal continues to be met.

WPS OPERATIONS REPORT, 1964

OPERATING HIGHLIGHTS

	1964	1963
Contracts in Force	241,430	218,345
Number of Claims Paid	191,386	165,025
Premium Income	$15,358,519	$13,238,864
Investment Income	220,071	186,311
Total Income	$15,578,590	$13,425,175
Claims Incurred	$13,795,996	$11,469,516

CONDENSED BALANCE SHEET, DECEMBER 31, 1964

WHAT WE OWN:	
Cash	$ 763,624
Receivables	728,029
Securities—Lower of Book or Market	5,462,254
Fixed Assets—Net	141,962
All Other Assets	85,667
TOTAL PROPERTIES	$ 7,181,536
WHAT WE OWE:	
Accounts Payable	$ 69,137
For Unreported and Unpaid Claims	2,670,000
Unearned Premiums	1,756,831
All Other Liabilities	30,902
TOTAL OBLIGATIONS	$ 4,526,870
TOTAL RESERVES	$ 2,654,666

CONDENSED STATEMENT OF INCOME AND EXPENSES

	Year Ended 12/31/64	% of Prem.
Earned Premium	$15,358,519	100.00
Benefits Incurred	13,795,996	89.83
Available for Operations and Reserves	$ 1,562,523	10.17
Operating Expense	1,709,772	11.13
Net Operating Income (Loss)	$ (147,249)	(.96)
Investment and Other Income—Net	220,071	1.43
Added to Reserves	$ 72,822	.47

ANALYSIS OF PREMIUMS AND BENEFITS

Twelve Months Ended December 31, 1964	Earned Premium Income	Benefits Incurred	Benefits as % of Income
Surgical-Medical	$ 8,208,653	$ 7,404,420	90.20
Hospital	7,149,866	6,391,576	89.39
Total	$15,358,519	$13,795,996	89.83

■ REPORT OF COMMISSION ON SCIENTIFIC MEDICINE—May, 1965

P. T. Bland, M.D., Westby, Chairman
G. E. Collentine, Jr., M.D., Milwaukee
John K. Curtis, M.D., Madison
T. V. Geppert, M.D., Madison
E. S. Gordon, M.D., Madison
James Weygandt, M.D., Sheboygan Falls
Warren Simmons, M.D., Rhinelander
W. T. Russell, M.D., Sun Prairie
Ovid Meyer, M.D., Madison
A. G. Martin, M.D., Milwaukee
Ex officio:
G. A. Kerrigan, M.D., Acting Dean, Marquette University School of Medicine
V. S. Falk, Jr., M.D., Edgerton, Medical Editor, *The Wisconsin Medical Journal*

Since last reporting to the House in October 1964, a number of teaching programs have been concluded and should be reported on; others are in the process of development and offer opportunities for physician instruction in the future.

I. "In Depth" Teaching Programs With U. of W.: In cooperation with the Madison Chapter of the Wisconsin Academy of General Practice and the University of Wisconsin Medical School (with supporting funds from the Merck Sharp & Dohme Postgraduate Program), a series of one-day conferences have again been held since October. They have been uniformly well received, and will probably be continued during the academic year of 1965–1966. Enrollment and actual attendance has been as follows: ("Net" represents M.D. paid registrations; "Gross" is total M.D. participation, including faculty and residents.)

	Net	*Gross*
Dermatology: "Eczemas and Related Diseases"	57	69
Pediatrics: "Common Childhood Anemias"	45	50
Surgery: "Colon and Rectal Surgery"	67*	83
Orthopedics: "Congenital Hips and Foot Deformities"	40	53
Gynecology: "Endocrine Problems in Gynecology"	38*	50
	247	305

* Because of severe weather, many of the unusually high registration did not attend:
Surgery: 25 registrants did not attend
Gynecology: 55 registrants did not attend (blizzard)

II. Circuit Teaching Programs: To afford physicians in northern Wisconsin access to State Medical Society teaching services, two March circuits were organized: one covering Sheboygan, Marinette and Antigo; the second with meetings held at Appleton, Wisconsin Rapids and Rice Lake. The first circuit was hampered by poor weather, but still more than 80 physicians were served. The second circuit was less successful, particularly in the Wisconsin Rapids area. A

total of 81 attended the three meetings. While the multiplicity of medical meetings suggests a limited number of circuit conferences, the Commission on Scientific Medicine hopes to continue at least one and possibly two circuits of this character in the North annually. Possibly summer conferences will be tried, as weather conditions in March are uncertain, and many Wisconsin physicians are out of the State on vacations at that time.

III. Visiting Professorships: An effort has been made to offer a "Visiting Professor" type of teaching service to hospitals, but to date no marked interest has been evidenced by hospital staffs contacted. Possibly this will be modified or dropped in 1965–66. In many ways the Commission feels these informal conferences can be more effective than the traditional evening lecture conducted before county medical societies (see comments on "Speakers Service" below).

IV. Speakers Service: During the past academic year nearly 50 county medical society meetings, plus several Council or District Meetings, have been provided speakers through the CES Foundation "Speakers Service." Most of the costs involved have been provided by support from the Merck Sharp & Dohme Postgraduate Program, the Wisconsin State Board of Health, and the Wisconsin Division of the American Cancer Society. The Wisconsin Heart Association withdrew support this past year, but has indicated a willingness to participate in the program next academic year. Outside of $500 donated to Milwaukee County for its fall teaching conference, the "Speakers Service" has been maintained without cost to the State Medical Society.

The Commission is concerned with the general decline of attendance at the county medical society meetings throughout the State. It was hoped that the "Speakers Service" might stimulate increased interest in scientific medicine, and improve attendance at county society meetings. This has not been the experience to date, and relatively few county societies are utilizing the service. Another problem has been how to provide speakers for the northern counties. Because of the remoteness of the two teaching schools from counties in the North, there has been an unwillingness on the part of many faculty members to take out the equivalent of two days from their work or teaching for a single visit in the North, often servicing a county society meeting with less than 10 physicians in attendance. The Commission will continue to study this problem, and it may wish to modify the direct teaching services now offered and place more emphasis on selected hospital staff visits, or a concentration in other avenues of education discussed in another portion of this report.

V. "Psychiatry In General Practice" Programs: The Commission was urged to develop special teaching programs for generalists in the area of psychiatry. In cooperation with the Division on Nervous and Mental Diseases, two such pilot programs were conducted in Sheboygan and Green Bay last November. As a result of financial support from several drug houses, these programs were conducted without any net expense to the Society membership, but with only 14 physicians participating in the Sheboygan meeting, and 25 registered at Green Bay there does not seem to be the tremendous interest in this subject which had been indicated to the Commission. The Division on Nervous and Mental Diseases will keep in touch with generalist groups to ascertain what type of teaching programs, if any, are preferred, and future plans in this area of instruction will be based upon valid requests for service.

New Avenues of Teaching

The Commission on Scientific Medicine is fully aware of the fact that changes in postgraduate medical education are taking place all over the U.S. Many state societies are confronted with the same basic problems as those encountered in Wisconsin. The shifting allegiance of many physicians to specialty programs or programs directly associated with the American Academy of General Practice indicates that the traditional education services of the State Society are possibly passé. In light of this obvious trend, the Commission is exploring other avenues of instruction, particularly that of Television and FM Radio.

I. Television: As a test, four original half-hour telecasts were developed this past year, in cooperation with the University of Wisconsin Medical School and Marquette University School of Medicine. These were telecast in the evening hours, on two consecutive days for each program, about 20 minutes after the educational station in Madison or Milwaukee terminated its regular programs. The physicians in the viewing areas were all notified twice concerning each program. The intensive publicity associated with these programs produced a sizable "audience." Generally speaking the comments on the programs were favorable, but the present costs ($2,100 for the four pilot programs), plus the restricted viewing areas at the present time would indicate that this form of physician education is too costly to develop on a comprehensive basis. If production costs become less, and coverage of the State is increased, this mode of instruction might well be developed as a continuing form of postgraduate medical education. But to be effective the programs have to utilize the unique advantages of television, and do more than visually duplicate a lecture as it might be conducted in a classroom. The test programs were seriously lacking in effective production, which could be improved through more experience and a greater appreciation of how best to utilize television as a part of medical postgraduate education.

II. FM Radio: Wisconsin offers unique opportunities of utilizing FM for postgraduate medical education. The State network is widespread, and nearly every part of the State is covered. Through FM Stereo Multiplex a "closed circuit" type of coverage is possible, and with the purchase of special equipment for less than $100 the individual doctor, or groups of doctors meeting in the hospital, can take advantage of this type of instruction.

At the present time the Commission is seeking a way by which such radio programs might be broadcast during an hour period between 12:00 noon and 1:30 p.m., with selected hospitals hooked up in a way to provide two-way communication. If these plans materialize, continuing instruction can be planned in cooperation with the two medical schools, and in terms of volume as well as quality of instruction this means of communication might offer instruction which would satisfy the needs of physicians throughout Wisconsin. Every effort will be made to develop this form of instruction during the coming year.

The Annual Meeting: This Year and Next

The 1965 Annual Meeting has been prepared in close cooperation with the various specialty societies

and the Wisconsin Academy of General Practice. Guest speakers from California, Boston, and points between will provide instruction. No expense has been spared to provide meetings which should prove satisfying to all members of the Society, whether specialists or generalists. Augmenting the instructional program a variety of high-quality Scientific Exhibits is provided, and they are worthy of physician attention. Members of the Commission on Scientific Medicine are hopeful that a record number of members will participate in the meetings, and give evidence of professional interest to the distinguished visitors from other states who are providing the lectures.

In 1966 the State Society celebrates its 125th Anniversary, and plans are already under way for an outstanding scientific program. The meeting will be held in La Crosse, and because of the physical facilities available there will be a somewhat different format of the program. Instead of specialty programs most presentations will be in "blocs" which will cover subjects of general interest to *all* members. A local program committee in La Crosse is working with the Commission to provide an instruction conference of unusual quality, and it is hoped that many members, particularly those in Milwaukee County who find it difficult to attend the Annual Meeting when held in their home community, will participate in the 1966 meeting.

In summary, many areas of instruction have been tried this past year. Some have met with unqualified success; others with somewhat discouraging physician response. The Commission will continue to explore new avenues of communication which might provide teaching to physicians without loss of professional time. Suggestions from members are always welcome, as the Commission's sole objective is to best serve members of the State Society.

■ REPORT OF COMMITTEE ON MILITARY MEDICAL SERVICE—May 1965

F. L. Weston, M.D., Madison, Chairman
O. G. Moland, M.D., Augusta
D. S. Arvold, M.D., Shawano
M. H. Steen, M.D., Oshkosh
J. M. Sullivan, M.D., Milwaukee

The Committee on Military Medical Service met to consider Special Call Number 36 for induction of physicians for entry on active duty July 1, 1965, or later.

Special Call Number 36 (physicians) was issued Feb. 25, 1965, for the induction of 24 Wisconsin physicians to enter on active duty after July 1. The call is restricted to physicians who will complete their internship training this year and who will be available after July 1.

The national call requested by the Department of Defense asks for a total of 950 physicians—550 to be assigned to the Army, 275 to the Navy, and 125 to the Air Force. State calls are not broken down among the Armed Forces. Assignment of physicians who are ordered to report for induction is made among the three services by the Department of the Army.

This call is to be filled by interns who have had no prior service; who have not accepted commissions in one of the Armed Forces or the Public Health Service; who are physically qualified; and who are not otherwise deferred.

Of the 135 interns who are registered with Wisconsin local boards, 69 are considered as of Mar. 8, 1965, to be available.

The committee reviewed each case of the 69 presented and in each instance made the recommendation that the intern be classified available. In one case, the committee unanimously recommended a deferment of liability for induction due to a severe hardship circumstance.

The committee's recommendation was made to the Wisconsin State Advisory Committee to Selective Service which in turn made the identical recommendation to the Wisconsin Selective Service System Headquarters.

■ REPORT OF COMMISSION ON PUBLIC POLICY—May, 1965

R. G. Zach, M.D., Monroe, Chairman
W. T. Russell, M.D., Sun Prairie, Vice-Chairman
L. J. Kurten, M.D., Racine
R. L. Gilbert, M.D., La Crosse
J. B. Durst, M.D., La Crosse
P. K. Odland, M.D., Janesville
J. A. Killins, M.D., Green Bay
S. A. Freitag, M.D., Janesville
G. O. Stubenrauch, M.D., Milwaukee
J. A. Kelble, M.D., Milwaukee
J. L. Teresi, M.D., Brookfield
G. M. Shinners, M.D., Green Bay
W. W. Moir, M.D., Sheboygan
H. E. Oppert, M.D., Viroqua
E. C. Quackenbush, M.D., Hartford
K. L. Siebecker, Jr., M.D., Madison
H. A. Peters, M.D., Madison
J. V. Bolger, Jr., M.D., Waukesha
J. S. Veum, M.D., Appleton
C. F. Broderick, M.D., Wisconsin Dells
J. M. Lubitz, M.D., Brookfield
W. P. Curran, M. D. Antigo, President
J. H. Houghton, M.D., Wisconsin Dells, President-Elect

Since last reporting to you, the Commission on Public Policy has been reorganized and now provides for a representative from each of the Scientific Sections of the Society, seven representatives from the membership at large, the President and President-Elect. This newly organized Commission on Public Policy met in September, its Executive Committee has met twice and the full Commission met in March and April.

The Wisconsin Legislature at the present time has over 970 bills pending for its consideration and approximately 114, or over 12 per cent, affect medicine in some respect. Your Commission has reviewed those legislative items that needed to be acted upon by the Society and I would like to call attention to the decisions recommended by the Commission. This report is designed to up date the House of Delegates on current legislation.

It will be necessary to supplement this material at the time of the May meeting because additional legislation will have been introduced and there will have been time to act upon certain measures now pending.

In 1963 the Legislature created Section 325.21 (2) of the Statutes relating to physicians and surgeons disclosing information of suspicious child injuries to a criminal law enforcement official or agency. This provision requires disclosure of information acquired in attending a patient in a professional character "in situations where the examination of an abused or injured minor creates a reasonable ground for an opinion of the physicians or surgeon that the condition was intentionally caused or inflicted by another and the child is unable or unwilling to disclose the facts and circumstances and the name of such another."

Four bills are pending that would require physicians and others to report cases of suspected child abuse to public welfare departments as well as to

law enforcement officials. The Commission in considering these bills decided that the Society should recognize the principle of reporting these suspected cases, but felt that immunity should be guaranteed for the physician when he is required to make these reports. It was emphasized that care should be taken to correct any provision in the legislation which would attempt to define physician in any other way than it is already defined.

Mental retardation testing has received a great deal of attention from various Society committees as well as numerous other organizations. Two bills have been introduced that would make testing of phenylketonuria (PKU) mandatory on the part of each hospital and maternity home and make the hospital administrator responsible for having the test or tests made.

The Commission on Public Policy after considering the recommendations of other Society committees felt that we as a Society should support testing for phenylketonuria (PKU) but that it should be pointed out to the Legislators that it was not desirable to make any test or tests mandatory. It is not advisable to include specific functions of medical practice in the Statutes, and in this particular instance, the tests are not conclusive enough to warrant compulsory action based upon a test that must have a voluntary follow-up to be accurate.

It was also felt that the present legislation should be amended to make the physician, not the hospital administrator, responsible for seeing that the testing is done because this is the practice of medicine.

A bill requiring labeling of dangerous drugs and stating that they cannot be delivered unless there is affixed to the immediate container a label disclosing the established name of the drug, if there is one, and the established name and quantity of each active ingredient if there are two or more has been considered. It was decided that the law already provides for the information that is needed and the Society should support the Pharmaceutical Association in their opposition to this bill.

A great deal of legislation has been introduced affecting safe transportation including standards for chemical tests for intoxication and "implied consent."

The Commission supports the general policy put forth in this legislation, but feels that the Society should work with the Wisconsin Nurses Association, the Wisconsin Hospital Association and the American Automobile Association in determining what is the best method of handling the problems that are currently being considered.

It was further recommended that the Society should limit its support to those aspects of the legislation which affect public health. The Commission also recommends to the House of Delegates, that it reverse its position supporting "implied consent" because the concept of "implied consent" is a legal matter and the Society should be concerned basically with the medical aspects of legislation.

Other legislation affecting safe transportation includes a bill requiring all applicants for renewal of motor vehicle operator's licenses who are age 65 or older to be re-examined, and a bill requiring application forms for licenses to state the blood type of the individual and if the licensee is a diabetic. Legislation making seat belts mandatory in all back seats beginning with the 1966 models has also been introduced.

It was felt by the Commission that this legislation should be supported by the Society, and the medical implications involved in these bills should be a matter of public health rather than one of enforcement through the police procedure.

In the area of mental health legislation, Joint Resolution 34, A. would create an interim committee of the Legislative Council to study all proposed revisions of the mental health Statutes. This is consistent with the position taken by the Commission in 1963 that any revisions to Chapter 51 should be done uniformly.

As in 1963, a bill creating an Interstate Compact on Mental Health has been introduced. The Commission feels that this should be considered by the proposed interim committee that would review any proposed changes in the mental health laws.

The Commission has worked with the State Board of Medical Examiners and supported its position that the Board should be allowed to increase the number of foreign licentiates to no more than 50 from the present 25. This legislation passed both the Assembly and Senate in March. The Commission also agrees with the position that resident physicians should be allowed to pay for their permanent licenses on a basis of ten dollars per year for not more than five years, and that the balance should be payable at this time. The Commission on Public Policy feels that legislation should be introduced on resident licenses, but has modified its original position somewhat. Originally it was felt that residents using this method of payment should be restricted to a resident teaching hospital, but this created a problem of locum tenens and the Commission plans to review the licensure of locum tenens as another matter.

Many amendments have been introduced concerning the Health Assistance Payments Act and the Commission on Public Policy supports Bill 27, A. which would repeal the requirement that a person must first spend 5 per cent of his annual income for health services before he is eligible for aid under the Act. Other amendments would repeal the requirement that payments for medical assistance under Kerr–Mills constitute a claim against the estate of the recipient, and Bill 222, A. would exclude from income limitations, in determining eligibility for the Health Assistance Payments Act, any social security benefits received. There is also pending legislation which would provide for hearing aids, glasses, "foot care and surgery" and a proposed bill providing for radiation therapy, but because of the fiscal requirements of the programs it was determined that the Commission should not actively support these proposals.

Two basic science bills have been introduced and are being supported by the Society. These bills attempt to up date an act which has not had substantial revision for forty years. One increases the per diem paid the Board members and the other adds the subjects of chemistry and bacteriology to those in which an applicant must be examined.

The Society on past policy is actively opposing Bill 277, A. which provides that Section 147.14 (3) . . . this is the Medical Practice Act . . . shall have an exception on the use of the title doctor by a duly licensed chiropractor. A licensed chiropractor would be allowed to use: "Doctor of Chiropractic," "Doctor," "Dr.," or "D. C." provided that he uses the word chiropractor after the title. This legislation has been reviewed by the Assembly Public Welfare Committee and they recommended that it be passed.

Legislation prohibiting opticians from filling contact lense prescriptions, even upon the orders of a physician is being opposed, and the Advisory Committee on Ophthalmology and the Commission on Public Policy are reviewing legislation which would attempt to elevate optometry to the status of a profession by prohibiting corporate practice of optometry. Legislation which would remove the definition of opticianry from the optometry Statutes and place it under the State Board of Medical Examiners is being reviewed with the Wisconsin Society of Opticianry.

■ REPORT OF COUNCIL—May, 1965

James C. Fox, M.D., La Crosse, Chairman

Activities of the Council through its October 1964 meeting have been reported to the House of Delegates in the two 1964 sessions. This report deals with actions of the Council in December 1964 and March 1965, and a special report will be submitted to the House with reference to the meeting just preceding the May session.

The chairman would like to comment that many of the reports and actions of committees and commissions referred to the House have previously been reviewed with the Council, and consequently, to avoid repetitious material, will not be included in this report.

By way of further comment, the educational campaign conducted by the AMA drew heavily on the time and resources of the State Medical Society, which retimetabled some of its activity in order to provide cooperative assistance in the early part of this year. This seemed a practical necessity, and federal legislative activity probably will command much of the time of various committees and the Council during the remainder of 1965 and quite possibly well into 1966. This report will not deal with any specifics until it is seen what definite action follows at the national level.

There is some considerable interest in various public health groups to develop concentrated efforts in the health career field. The Wisconsin Health Council, Inc., of which the Society is a member and which it supports in providing office facilities, is the body through which there will be coordinated activity if sufficient finances can be raised. The Society provides at the present time a staff member to serve as executive secretary to the WHC, and in other ways is cooperating with this project, a matter of increasing concern to the welfare of the state and nation as a whole.

Guides for athletic disqualification, junior and senior high school level, on impairment of vision, and on exercise fitness, have been approved or purchased and distributed to appropriate educators and other public bodies, and in the overall field of health examinations the following resolution recommended by the Division on School Health was adopted by the Council:

"WHEREAS, Exercise is an essential element in achieving physical fitness and total fitness; and

"WHEREAS, Practices and patterns established in early life are strong determinants in maintaining levels of fitness in adult life; and

"WHEREAS, There are so many influences in the daily lives of school age children which interfere with the natural tendency to keep and maintain bodily efficiency; and

"WHEREAS, The school, along with the family and the community, has a concern with the fitness of our youth; and

"WHEREAS, The physical education programs in schools have been the concern of the educator, the physician, the parent, and the community, to make them more effective and expand their benefits to all students; and

"WHEREAS, A statutory requirement dealing with the amount of time devoted to physical education has been removed, and could result in deemphasis of physical education programs in our schools; now therefore be it

"*Resolved*, That physicians, individually and through their county medical societies, direct their attention particularly to that portion of the curriculum devoted to physical education with emphasis on: (1) adequate allotment of time devoted to the subject, (2) equal emphasis on programs for both boys and girls, and (3) more use of facilities during out-of-school time."

In discharge of other assignments approved by the House of Delegates, the third annual Wisconsin Work Week of Health was held and proved highly successful. A summary report appears at the end of this report.

A number of scientific teaching programs have been held, and the conference on Health Fads and Fallacies will later be reported with any recommendations from the Commission on Public Policy.

The past presidents have been appointed a standing committee of the Council with their current major responsibility being to plan activities in 1966 in celebration of the Society's 125th Anniversary. Also assigned to this committee is the matter of an established program for assistance to those physicians who may be in financial need. This will be reported later.

The Council desires to mention that the first Scientific Fellow was elected in March—Alvin L. Berman, Ph.D., Associate Professor of Anatomy at the University of Wisconsin—and later announcement will be made of the two institutions voted special citation for their services in community welfare.

The Council has been concerned with planning details for the 1966 Annual Meeting in La Crosse, and among other things recommends to the House that it approve a schedule for 1966 meetings as follows: First session at noon on Monday, with reference committees meeting about three o'clock and concluding by dinner time; second and third sessions held consecutively beginning at three o'clock on Tuesday and concluding by six o'clock. These recommendations are intended to provide delegates with maximum opportunity to participate in evening affairs planned in La Crosse, and of course, to attend the scientific program.

Ovid Meyer, M.D., of Madison, was elected as co-editor for the University of Wisconsin of the Comments on Treatment page in the WISCONSIN MEDICAL JOURNAL, and Messrs. Earl R. Thayer and S. E. Gavin, Jr., have been elected non-medical trustees of the CES Foundation, with Norman J. Salt being confirmed as staff giving virtually full time in direction of affairs of the Foundation.

The Council reports that Resolution No. 1 introduced by the Fond du Lac County Medical Society in October 1963, concerning relationships with the State Department of Public Welfare, which was referred to the Commission on State Departments, is recommended for tabling by the Division on Public Assistance.

In the March meeting the Council authorized the president and president-elect to develop a statement relative to salaries of state-employed physicians, to be submitted to the Department of Administration which is concerned with the matter. Doctors Curran and Houghton approved the following statement which was officially filed on Mar. 16, 1965:

"The State of Wisconsin, through its agencies and bureaus, has many positions requiring the services of a physician who serves not only in administering public health programs for the people of the state, but in many instances is concerned with patient care in state institutions.

"At the present time there are openings for additional physicians, and in some instances there have been vacancies in certain positions for a considerable period of time.

"Only by establishing a realistic salary schedule can the State of Wisconsin offer its citizens proper standards of health care. Because of this the State Medical Society of Wisconsin encourages the Department of Administration to revise salary schedules in the interest of securing and holding well

qualified physicians in this area of public health necessity."

In mid-January the Supreme Court directed that on Mar. 5, 1965, it would hear arguments on the creation of a proposed rule applicable to personal injury actions. By its terms a trial court could order an examination of the injured person and a report by "an impartial medical expert" where in the court's opinion such examination and report would be of material aid to the determination of the case.

The rule also provided that the court would make the appointment from a panel of doctors of medicine designated for their qualifications by the State Medical Society after consultation with a committee of the State Bar of Wisconsin.

After polling the Council, associate general counsel of the Society, Mr. John A. Kluwin, was authorized to appear on behalf of the Society at the hearing before the Supreme Court. He did so and requested that the matter be postponed so as to permit an adequate time for study by the State Medical Society and others interested in it. Substantial opposition to the rule was shown at the time of the hearing, including all the circuit judges of the state.

On March 30 the Supreme Court announced that it would not adopt the proposed rule at the present time "for the reason that all trial judges in Milwaukee County (the area where the greatest use of the proposed procedure would be expected) are opposed to the adoption of the rule, and there is no apparent support for such procedure in the medical profession."

The order also stated that the court awaited the results of the study now being made of the subject by Milwaukee lawyers and doctors and that the court would take no further action on such a rule until after Jan. 1, 1966, by which date it was hoped that such study would be completed.

In the interim, the State Society has the opportunity to make such recommendations as it believes appropriate for the entire state.

There are a number of assignments which the Council and its committees are in process of studying and developing with later report to the membership and the House of Delegates.

The Council Committee on Economic Medicine is in conference with the Society's insurance consultants, Seefurth–McGiveran of Milwaukee, in a project to provide increased and further benefits in our group insurance program.

The State Department of Public Welfare is cooperating with the Selective Service in urging eligible rejectees to seek rehabilitation services. The Society's cooperation is being sought and the matter is under study.

Creation of the position of historian has been a subject of discussion for several years. Until more pressing matters are discharged, the Council has laid aside a study of how to effectively develop this to a later date, but the subject remains on the pending agenda.

The Executive Committee of the Council has held periodic and successful joint meetings with a similar body of the Wisconsin Hospital Association. It had scheduled a similar meeting with the Wisconsin Pharmaceutical Association, but weather conditions necessitated cancelling the entire meeting which will be held at a subsequent date.

The Planning Committee has been assigned the matter of creating an area hospital planning committee similar to that now existing in Milwaukee County.

The Council continues to follow closely the current legal status of professional service corporations and has assigned the technical details to general counsel Murphy and associate general counsel Kluwin.

The Executive Committee of the Council has accepted the assignment for the time being of reviewing all federal legislation to the extent it is of concern to the State Medical Society. Later reports of the Executive Committee may be anticipated.

The Council has authorized participation in joint voluntary efforts to conduct an accreditation survey upon request of an unaccredited hospital. There are some 60 such hospitals in the state, and under federal legislation, if it is enacted, a hospital in order to participate in the insurance program for the aged will be acceptable if it is accredited or provides the government with reasonable assurance that basic conditions have been met if it is not accredited.

The Council met with representatives of the Woman's Auxiliary at its March meeting, and ways and means of furthering and assisting activities of the Auxiliary are now under consideration.

Necrology Report

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in italic.

J. B. Wear, M.D., Madison
B. A. Lungmus, M.D., Milwaukee
F. W. Van Kirk, M.D. San Francisco, Calif.
R. M. Stark, M.D., Milwaukee
G. T. Hegner, M.D., Appleton
J. H. Young, M.D., Elkhorn
A. F. Harter, M.D., Eveleth, Minn.
E. E. Carl, M.D., Milwaukee
W. C. Maas, M.D., Rio
H. H. Schlomovitz, M.D., Milwaukee
P. J. Eisenberg, M.D., Milwaukee
M. H. Wirig, M.D., Madison
E. A. Strakosch, M.D., Oshkosh
L. M. Lifschutz, M.D., Racine
E. E. Carpenter, M.D., Superior
V. J. Taugher, M.D., Berlin
W. P. Zmyslony, M.D., Milwaukee
L. W. Egloff, M.D., Pewaukee
J. H. Karsten, M.D., Horicon
Dorothy Mendenhall, M.D., Madison
T. H. Jayners, M.D., Hendersonville, N.C.
S. H. Wetzler, M.D., Milwaukee
T. S. Burdon, M.D., Green Bay
P. J. Dailey, M.D., Elcho
W. A. Werrell, M.D., Madison
A. S. Jackson, M.D., Madison
F. H. Kennedy, M.D., Waterloo
W. A. Langmack, M.D., Rio
J. W. Shaw, M.D., Manitowoc
J. P. Healy, M.D., New Richmond
M. P. Gratiot, M.D., Shullsburg
Milton Feig, M.D., Madison
G. F. McKay, M. D., Milwaukee
J. J. Brook, M.D., Milwaukee
M. E. J. Wiese, M.D., Milwaukee
A. J. Randall, M.D., Kenosha
Charles Merulla, M.D., New Berlin
G. H. Chesky, M.D., Brookfield
W. D. Stovall, Jr., M.D., Manteno, Ill.
S. B. Pessin, M.D., Milwaukee
L. J. Unterholzner, M.D., Blanchardville
J. A. Megna, M.D., Milwaukee
W. H. Marsden, M.D., Madison
Howard Barry, M.D., Sun Prairie
Julius Blom, M.D., Eau Claire
W. J. Frawley, M.D., Appleton
J. F. Henken, M.D., Racine
N. E. McBeath, M.D., Milwaukee
E. J. Mittermeyer, M.D., Cornell
Bernhard Kaufman, M.D., Milwaukee
R. J. Groves, M.D., Lodi
J. H. Weisberg, M.D., Superior
W. J. Bleckwenn, M.D., Winter Haven, Fla.

E. H. Federman, M.D., Princeton
E. L. Riee, M.D., Milwaukee
W. G. Meier, Jr., M.D., Sheboygan
J. P. McMahon, M.D., Milwaukee
L. W. Peterson, M.D., Sun Prairie
E. A. Pohle, M.D., Madison
Samuel Rosenthal, M.D., Milwaukee
G. E. Forkin, M.D., Menasha
Josef Seilin, M.D., Antigo
G. F. Fitzgerald, M.D., Milwaukee
N. O. Gunderson, M.D., Madison
D. F. Doyle, M.D., La Crosse
W. A. Joseph, M.D., Hales Corners
H. D. Ludden, M.D., Mineral Point
W. C. Liefert, M.D., Milwaukee

WISCONSIN WORK WEEK OF HEALTH

February 22–26, 1965
Report to the Council
March 13–14, 1965

The Wisconsin Work Week of Health was initiated in 1963 for the purpose of providing a forum where matters of interest to the medical profession, allied health groups, and the general public might be discussed.

By combining several topics into one week-long series of conferences, the attention of the public and the allied health groups is focused upon them and upon the information which is presented.

During the past three years the topics have changed, and yet the over-all concept remains the same—to review our health personnel, our facilities, areas which need attention, including patients who have special problems, as well as explaining the advances in the health care field.

While the concept of the Wisconsin Work Week of Health has been on an annual basis since its inception in 1963, the Council may wish to consider maintaining the same schedule or adopting a different schedule.

Planning

The planning of the Wisconsin Work Week of Health this year was the responsibility of the Executive Committee of the Council which undertook its obligations early in the fall of 1964.

Included in the planning for the various conferences of the Work Week of Health in addition to the Council, was the Division on School Health, the Commission on Public Relations and Communications, the Commission on Hospital Relations and Medical Education, the Division on Nervous and Mental Diseases as well as the Division on Aging.

Sponsorship

The program of the Wisconsin Work Week of Health carried many sponsors which are listed elsewhere. The role of the sponsor to the Work Week of Health should be redefined in that the intended result of attracting large numbers of members of the sponsors was not attained this year nor in the preceding two years.

The co-sponsors generously gave of their time and suggestions when asked, and none approached refused to allow the name of its organization to be used as a co-sponsor.

It is believed, however, that a limitation of sponsorship with real emphasis upon planning a program with a co-sponsor may be more effective as far as attendance and relationship with that organization than merely listing large numbers of co-sponsors.

Program Development

While it was attempted to attract speakers and discussants of national reputation, it was found that aside from the program on February 24 at which the Medical Director of the Food and Drug Administration was present, most of the other speakers were either local or confined to the immediate area with the exception of those who came also from Washington, D.C.

Suggestions

Again in 1965 suggestions were solicited from the audience which responded with 90. Most prevalent among the suggestions were programs on rehabilitation, retardation and alcoholism.

Work Assignments

Members of the staff who participated in planning and in conducting the Wisconsin Work Week of Health did a fine job and much credit is due to each one of them, listed below.

C. H. Crownhart	J. M. Anderson
R. T. Ragatz	Leona Chesemore
R. H. Hansen	Beverly Radock
R. E. Koenig	Marguerite Cordts
H. B. Maroney	Carol Cowan
N. J. Salt	Joan Pyre
R. D. Mitchell	Donald Pazynski

D. C. Reynolds

Summary

A decision as to the types of programs which may then attract meetings of State Medical Society Committees, Commissions and Divisions, should be made so that if it is believed that each evening of the Wisconsin Work Week of Health should he devoted to one or more meetings of Society Committees that these Committees then play a more active part in the selection of the program for the day of, or day following their meetings, than has been true in the past.

Co-Sponsors

American Medical Writers' Association
Board of Criminal Court Judges
Communications Division of the American Medical Association
Department of Drugs of the American Medical Association
Department of Medicine and Religion of the American Medical Association
Diocese of Madison
Mental Health Advisory Committee
State Bar of Wisconsin
State Board of County Court Judges
State Board of Health
State Department of Nurses
State Department of Public Instruction
The University of Wisconsin College of Agriculture
The Wisconsin Council for Retarded Children, Inc.
Wisconsin Association for Mental Health
Wisconsin Congress of Parents and Teachers, Inc.
Wisconsin Cooperative Extension Service
Wisconsin Council of Agriculture Co-operative
Wisconsin Council of Safety, Inc.
Wisconsin Farm Bureau Federation
Wisconsin Health Council, Inc.
Wisconsin Hospital Association
Wisconsin Juvenile Officers Association
Wisconsin Nurses Association, Inc.
Wisconsin Pharmaceutical Association
Wisconsin Public Health Association
Wisconsin Public Welfare Association
Wisconsin Society of Hospital Pharmacists
Wisconsin State Dental Society
Wisconsin State Department of Agriculture
Wisconsin State Grange
Wisconsin State Medical Assistants Society

Wisconsin State School Health Council
Wisconsin Youth Committee for Community-Youth Participation

Attendance

February 22 (Monday)	216
February 23 (Tuesday)	247
February 24 (Wednesday)	222
February 25 (Thursday)	213
February 26 (Friday)	349
	1,247
Those who didn't register a second time and walk-ins to Council Room	75
Speakers, moderators	58
	1,380

Press, Radio and TV Coverage

Newspapers, UPI, AP reporting
Lineage ..... 519 inches
Radio—State FM network Time ..... 30 minutes
Television Time ..... 2 hours 17 minutes
Plus assorted radio and television newscasts.

Woman's Auxiliary

Members of the Woman's Auxiliary to the State Medical Society who served as hostesses in the Council Room during the Wisconsin Work Week of Health were:

Monday—Mrs. Rolf A. Quisling and Mrs. Alwin E. Schultz, both of Madison.
Tuesday—Mrs. J. Howard Johnson, Milwaukee, a past state president of the Auxiliary.
Wednesday—Mrs. J. J. Satory, La Crosse, president; Mrs. F. H. Wolf, La Crosse, president-elect; Mrs. David Hammes, Green Bay, treasurer; and Mrs. W. D. James, Oconomowoc, immediate past-president.
Thursday—Members of the Woman's Auxiliary to the Dane County Auxiliary, Mrs. T. W. Tormey, Mrs. H. C. Ashman, and Mrs. L. E. Holmgren, and Mrs. J. J. Satory, La Crosse.
Friday—Members of the Woman's Auxiliary to the Milwaukee County Medical Society, Mrs. J. J. Levin, current president; Mrs. R. C. Johnson; Mrs. Thomas Leitschuh; and Mrs. A. J. Baumann, a past state president.

Letters of Commendation

I attended the Tuesday morning meeting of the Third Annual Work Week of Health and I was very impressed with the way that you handled this problem and the manner in which you presented it.

I thought that the speakers you chose were excellent and were men of great experience. Their presentation of material made people realize that the individual could do something in regard to the population explosion.

I am very happy that the Wisconsin Youth Committee for Community-Youth Participation could be a co-sponsor of the work week.

QUINN MARTIN, *President*
Wisconsin Youth Committee
Madison, Wisconsin

While the most immediate stimulus for this letter is to express my thanks for the Wisconsin cheeses you so thoughtfully sent, I want to comment also on the excellence of your arrangements for the Wisconsin Work Week of Health. I cannot recall a program so well planned, handled and executed or offering so much consideration for speakers as well as audience.

It was an unusual pleasure, too, to visit the headquarters of the State Medical Society of Wisconsin. The thought which has gone into the development and furnishing of your building has produced handsome results. I was filled with admiration.

The overall product speaks highly of your staff as well as of your own leadership, needless to say. I particularly wish to express my appreciation of Messrs. Reynolds and Mitchell. They could not have been more helpful.

F. GORDON DAVIS
F. Gordon Davis and Associates
Public Relations Consultants
Birmingham, Michigan

I want to personally express my appreciation for the opportunity to participate on the Monday session of the Third Annual Wisconsin Work Week of Health. Also, on behalf of the A.M.A. Council on Rural Health, we were particularly happy to cooperate with the State Medical Society of Wisconsin in planning for the Monday session on "Health Problems of Our Population."

Your planning and arrangement for the details of the meeting were outstanding, and we congratulate you on a job well done.

Mrs. Bible and I want to thank you for the most delicious cheese you mailed to us. There is no other cheese that can compare with the Wisconsin product.

BOND L. BIBLE, Ph.D.
Secretary, Council on Rural Health
American Medical Association
Chicago, Illinois

The Wisconsin Council for Retarded Children wishes to congratulate the State Medical Society for another extremely successful Work Week of Health program. We are proud to have been a participating organization.

Having only recently joined the Council in this state, it was my first exposure to the Work Week of Health. I had heard that it was an outstanding event and now upon observing it, the lavish praise is understandable.

Good luck on future Work Weeks of Health. Our interest in them continues to grow.

MERLEN G. KURTH
Executive Director
Wisconsin Council for Retarded Children, Inc.
Madison, Wisconsin

We wish to express special appreciation to the State Medical Society for presenting the Work Week of Health.

Members of our staff were privileged to attend several of the programs. We are in enthusiastic agreement that the programs were outstanding. We appreciate the experts of national and state repute whom you brought to us, the content which they presented, the seemingly untiring efforts of your staff for detail, and the comfort of your guests. We cannot commend you enough.

You have provided a most commendable service for the medical community, as well as the community at large.

Our best wishes and gratitude to you.

ADELE G. STAHL, R.N., *Director*
State Department of Nurses
Madison, Wisconsin

The Actions and Statements section of the 1965 "Work Week of Health" program contains two statements on tuberculosis, including a reference to physician cooperation with the Wisconsin Anti-Tuberculosis Association in its efforts to eradicate tuberculosis.

Our president, Mrs. Konrad Testwuide, Jr., brought these statements to the attention of the WATA Executive Committee at its March 1 meeting. The Committee was pleased with the inclusion of these statements in the program and asked that

its appreciation be transmitted to the State Medical Society.

C. W. Kammeier
Executive Secretary
Wisconsin Anti-Tuberculosis Association
Milwaukee, Wisconsin

REPORT OF SECRETARY—May 1965

C. H. Crownhart, Secretary

There must be some apt way to describe the activities of the Secretary's office. . . . I can say that since the October session of the House it has been going great guns. Attached to this report is a chart, for a 15-month period, showing meetings with which the staff has been associated. It is a considerable number, involving not only preparation and research related to agenda items, but recording action and seeing that those actions are appropriately carried forward.

Without question, the finest achievement of the last three years has been the development of the Work Week of Health. By careful planning, some thousands of persons are informed of the position of the Society on many matters of health concern. Instead of large mailings on specialized subjects, the WWWH program incorporates these positions and the achievements of medicine. This year the pro-

STATE MEDICAL SOCIETY OF WISCONSIN

Meetings of commissions, committees and subcommittees	1/64	2/64	3/64	4/64	5/64	6/64	7/64	8/64	9/64	10/64	11/64	12/64	1/65	2/65	3/65
HOUSE OF DELEGATES					ANNUAL MEETING HOUSE OF DELEGATES					FALL					
Committee on Cancer	x														
Grievance Committee	x							x							
Commission on PR and Communications			x						x	H D					
a) Medical Assistants Advisory															
b) Occupational Health											x				
Commission on Scientific Medicine				x					x		x		x		
Commission on Public Policy		xx		x					x						x
a) Executive Committee													x		
b) Ophthalmology Advisory		x		x							x	x			x
Commission on Hospital Relations and Medical Education	x						x			x		x		x	
Woman's Auxiliary Advisory															
COUNCIL COMMITTEES															
Disaster Medical Care															
Editorial Board WMJ															
Military Medical Service					x										x
Health Economics of American Life		x													
Commission on Medical Care Plans				x				x				x			x
a) Executive Committee	x	x					x		x				x		
b) Utilization Committee															
c) Wisconsin Health Service	x	x													
d) Medicare Committee								x					x		
e) Dental Liaison Committee															
Commission on State Departments			x			x					x				x
a) Div. on Aging		x							x			x			
b) Div. on Chest Diseases												x			
c) Div. on Handicapped Children													x		
d) Div. on Maternal and Child Welfare									x						
1) Maternal Mortality Study									x						
2) Nurse Responsibility Study										x		x		x	
e) Div. on Nervous and Mental Dis.	x	x				x			x			x			
1) Com. on Commitment Laws						x						x			
2) Psychology Subcommittee									x			x			
f) Div. on Public Assistance										x					
g) Div. on Rehabilitation			x										x		
h) Div. on Safe Transportation		x										x		x	
i) Div. on School Health		x							x						
j) Div. on Visual and Hearing Def.		x								x					
1) Subcom. on Visual Prob.										x					
2) Subcom. on ENT															
Committee on Clinical Medicine															
Past Presidents				x					x						
COUNCIL AND COMMITTEES															
Council			x		xx			x		x		x			x
a) Executive Committee	x	x			x		x	x	x		x			x	x
b) Scientific Medicine			x							x					
c) Economic Medicine					x			x							x
d) Planning					x	x		x		x					
e) Finance		x	x					x	x					x	
CES FOUNDATION															
Board of Trustees					x										
a) Executive Committee									x						x
b) Scientific Committee (Commission on Scientific Medicine)															
c) Permanent Commission—MMP & SHH		x							x						
AD HOC COMMITTEES															
Menominee County Study (CES)		x		x				x							
Section Organization	x														
Redistricting—Councilor Districts															
SMS REALTY CORPORATION															
Membership			x												x
Board of Trustees			x											x	
Total 54 entities	8	15	8	6	7+HD	4	3	9	15	8+HD	5	11	6	6	10

gram warranted Governor Knowles' attention in recognizing the Society's efforts through proclaiming the Wisconsin Work Week of Health. The more than 1,200 visitors to the building during the five-day program show strong evidence of interest in the total effort.

If the Secretary has any regret, it is that the Work Week of Health was not started much earlier. Its effect will be cumulative. It enables the Society to state many of its positions efficiently and to a wide range of civic interest. It ties a thread to actions year in and year out. Visitors are impressed with the broad scope of efforts by the Society, and out-of-state program participants see action implemented in fact.

The Educational Campaign of the AMA and our legislative problems in Madison remain an activity of consequence. One major difficulty is that the Legislature (theoretically, at least) is in general session once in alternate years. This calls for staff and consultant time to the temporary detriment of other activities. Of the some 1,800 bills anticipated this year, at least 10% will involve public health to some degree. An up-to-date report will be submitted to the House when it convenes.

The affairs of the Foundation have added impetus with the promotion of Norman J. Salt to give coordinated direction to its various projects. The Executive Committee approved holding the Annual Meeting of Trustees apart from the occasion of the Annual Meeting of the Society. To the Secretary, this is a wise move. It will give the trustees both the time and opportunity to review activities and probably spur on the inquiring mind. An interim report is being submitted to the House for information, and your Secretary feels certain that it emphasizes the stature of the Foundation and its growing ability to service public health needs of Wisconsin. Possibly one of its landmarks will be the report on Menominee County submitted to the House last fall. Your Secretary can report his opinion that this survey crystallized the need of a comprehensive, well planned approach in this geographic and ethnic area of Wisconsin.

During the past year, the Society's administrative policy of employment has been reviewed by

MEMBERSHIP REPORT

State Medical Society of Wisconsin

TOTAL MEMBERSHIP BY COUNTY

DECEMBER 31, 1964

County Society	Regular	Resident	Associate	Affiliate	Life	Military	Honorary	Educational	Special Service	Career Appointment	Total
Ashland-Bayfield-Iron	17		1		1						19
Barron-Washburn-Sawyer-Burnett	30	3									33
Brown	124	1	1	1	1	1					129
Calumet	9										9
Chippewa	24										24
Clark	13	1									14
Columbia-Marquette-Adams	28	1	1		1						31
Crawford	9										9
Dane	375	37	9	5	5	8	3	20	1	8	471
Dodge	45	1	1	1							48
Door-Kewaunee	19	1									20
Douglas	23				1						24
Eau Claire-Dunn-Pepin	83	2	4	1	3						93
Fond du Lac	71	3	1		3	1					79
Forest	4			1							5
Grant	28		2		1						31
Green	37	1	1	1	1						41
Green Lake-Waushara	13	1			1						15
Iowa	9				2						11
Jefferson	32	3			1						36
Juneau	6										6
Kenosha	76	1	1	2	1				1		82
La Crosse	94			4	2						100
Lafayette	5			1							6
Langlade	14	1		2							17
Lincoln	12		2								14
Manitowoc	48				1						49
Marathon	66			2		1					69
Marinette-Florence	17	1	1		1						20
Milwaukee	1220	68	21	18	16	9	5	7	2	7	1373
Monroe	13		1		1						15
Oconto	8	1									9
Oneida-Vilas	26		2								28
Outagamie	85	1			2						88
Ozaukee	18										18
Pierce-St. Croix	30		1		1	1			1		34
Polk	19	3		2							24
Portage	27										27
Price-Taylor	11					1					12
Racine	116			6	5	1	1				129
Richland	12										12
Rock	107		4		3						114
Rusk	5										5
Sauk	20	1		5							26
Shawano	17	1									18
Sheboygan	72		4		2						78
Trempealeau-Jackson-Buffalo	20	1	2		1						24
Vernon	16		1	1							18
Walworth	29					1					30
Washington	26		1	2	1						30
Waukesha	107	2	1	1	1	1					113
Waupaca	21	1									22
Winnebago	92	1	1	1	4						99
Wood	76				1						77
TOTALS	3524	138	64	57	64	25	9	27	5	15	3928

federal authorities, and it has not been found wanting. It is "an equal opportunity employer" by reason of its contract with ODMC for the provision of benefits for dependents of men in service, and its agreement to underwrite the insurance program for federal employees.

In another area, the Society has appeared twice in the Wisconsin Supreme Court, one being to uphold the contention that podiatrists are not physicians and surgeons under the Wisconsin Medical Practice Act. The other appearance was in the nature of asking for opportunity to study a proposal permitting trial courts in this state to impanel medical experts in personal injury actions. This is referred to in the report of the Council included in the handbook for delegates.

Accompanying this report is the count of members by county in various classifications at the end of 1964. Last May the Reference Committee on Reports of Officers asked that the number of licensed physicians who are non-members of the Society be reported. This necessitated a check of records of the State Board of Medical Examiners, and there were found to be 702 such physicians. Some are residents and others have retired from practice. No study has been made to ascertain the actual number in private practice.

Before turning to statistics, the Secretary would point out that much of the work of the office is reflected in the various reports distributed to you.

Membership Report

(For the year ending December 31, 1964)

Members paying no dues		160
Affiliate members	57	
Military service members	25	
Honorary members	9	
Life members	64	
Special service	5	
Total	160	
Members paying pro rata dues (military service returned and new after July 1)	70	
Associate members	64	
Members in residency training	138	
Members paying full dues	3469	
Educational members	27	
Total	3768	
Total membership		3928

■ PRELIMINARY REPORT OF AD HOC COMMITTEE ON REDISTRICTING

F. E. Gehin, M.D., Stevens Point, Chairman
Gerold J. Derus, M.D., Madison, Secretary
F. M. Hilpert, M.D., Racine
E. P. Rohde, M.D., Galesville
De Lore Williams, M.D., West Allis
R. T. McCarty, M.D., Milwaukee
John F. Walsh, M.D., Port Washington
R. G. Strong, M.D., Manitowoc
J. V. Balger, Jr., M.D., Waukesha
C. A. Olson, M.D., Baldwin

This committee, created by the House of Delegates in October 1964 and appointed by a special committee consisting of the President, Chairman of the Council, Speaker and Vice-Speaker of the House, held its organizational meeting on April 10, 1965. There is one member from each Congressional District.

A chairman and secretary were selected, the committee's assignment was discussed with the President and Speaker being present, and arrangements were made for future meetings to be held in conjunction with the Annual Meeting in Milwaukee. A supplementary report may be available at that time.

■ RESOLUTION NO. 1

Introduced by: Richland County Medical Society

WHEREAS, The members of the Richland County Medical Society have become acutely aware of the shortage of General Practitioners in the State of Wisconsin and the nation as a whole; and

WHEREAS, We feel that a prominent cause of the shortage of the General Practitioners is due to the direction taken by teaching institutions in general, the University of Wisconsin and Marquette Medical Schools in particular; now, therefore, be it

Resolved, That we would like to see established a chair of general practice on the staff of the two mentioned medical schools and a General Practice residency or a rotating internship at the involved hospitals, in order to more clearly direct the schools to a more general field of medical teaching than is now obtained with the emphasis on specialties.

■ RESOLUTION NO. 2

Introduced by: Manitowoc County Medical Society

Resolved, That the State Medical Society recommend that the bylaws of all the hospitals in the state of Wisconsin, upon the staff of which are members of the State Medical Society, contain a provision in the bylaws of the staff of each hospital providing that before an appointment to the staff of said hospital be revoked, withdrawn, suspended, canceled, or not renewed, the doctor affected shall have the right to a hearing and have such counsel as he may select; and that he be given notice in writing of the time of the hearing within a reasonable period before such hearing.

■ RESOLUTION NO. 3

Introduced by: Sheboygan County Medical Society

WHEREAS, Our aging population is increasing and many indigent older people will require financial help with their medical problems; and

WHEREAS, An expanded and complex medical care bill for the aged is about to be passed by the Congress; and

WHEREAS, The medical profession is so directly involved and may lose its independence and become a group of civil servants; therefore be it

Resolved, By the House of Delegates of the State Medical Society of Wisconsin, that the medical profession be placed in control of the maintenance of an intimate doctor-patient relationship; all methods and means of treatment—and continuation of the free choice of physicians; and be it further

Resolved, That on all boards and committees empowered to direct and supervise the general administration of the Act; the amount of and distribution of fees—and the selection and approval of hospitals and nursing homes—the doctors should be represented fully.

■ RESOLUTION NO. 4

Introduced by: Brown County Medical Society

Resolved, That the State Medical Society of Wisconsin engage the services of a competent full time staffman to devote his time to representing medicine's views in the rapidly developing mental health programs and planning, and that the State Medical Society, if necessary, increase its dues to provide the cost of this position as per the financial estimate of the Division on Nervous and Mental Diseases.

■ INFORMATIONAL REPORT OF THE BOARD OF TRUSTEES of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin—May, 1965

The Executive Committee of the Board of Trustees of the Charitable, Educational and Scientific Foundation has met twice since May of 1964. This report represents the activities that have taken place since May of 1964, but it does not attempt to be a complete report on the projects of the Foundation. This is because the Board of Trustees is scheduled to meet at the Museum of Medical Progress and Stovall Hall of Health during the summer months of 1965 rather than at the time of the Annual Meeting of the Society.

A further report will be made available to the House of Delegates from the Board of Trustees at the interim session scheduled for October.

During 1964, the Student Loan project was the beneficiary of funds from the Woman's Auxiliary of the State Medical Society; A. M. Schwittay, M.D. for Ruth Coe, R.N.; and from Albert Popp, M.D. of Milwaukee. While these represent donations to create special loan funds, many general contributions have been made. These donations are listed in the Report on Contributions for the year 1964 and are attached.

In addition to the creation of regular Student Loan accounts, surplus funds from the "Sabin-On-Sunday" clinics have been donated by several county medical societies. Scholarship loans have been established, under the direction of the Foundation, by Grant, Dane, Outagamie and Marinette County Medical Societies and are made available to residents of these counties. Students in the fields of nursing, dentistry, pharmacy and medicine benefit from the "Sabin-On-Sunday" loan programs.

At the present time, the Foundation has loaned over $135,000.00 to students and for the 1964–65 academic year twenty-nine (29) medical students, one dental student and one nursing student were assisted.

Last year over $21,000.00 was loaned and this has been the largest demand on Foundation funds for student assistance in any year since the program began. While many individuals and organizations have been generous in their contributions, if the need continues to grow, as past experience has demonstrated, it will be necessary for more physicians and friends of medicine to make additional funds available.

In the area of scientific teaching and postgraduate education the Foundation, under the auspices of the Commission on Scientific Medicine, has participated in eight "In Depth" teaching programs during the past year. These programs were sponsored in connection with the University of Wisconsin.

Circuit teaching programs have taken place in Sheboygan, Marinette, Antigo, Appleton, Wisconsin Rapids and Rice Lake, and a special program of psychiatry in general practice was held in Sheboygan and Green Bay.

Speakers Service to county medical societies have included over thirty-nine (39) actual speaking engagements and this program is operating very effectively.

The Foundation, in addition to its regular scientific teaching programs, sponsored three memorial lectures. The first of these is the Beaumont Lecture and the second is the Conrad Elvehjem Memorial Lecture that is to be presented on the subject of one of the basic sciences. The third memorial lecture is one honoring Wilson Cunningham, M.D. of Platteville, Wisconsin, and this lecture varies from wholly scientific topics to those concerning general public health activities.

The Museum of Medical Progress and Stovall Hall of Health were under the management of the Charitable, Educational and Scientific Foundation during the 1964 site season. Over 15,500 visitors from 45 states and 10 foreign countries were registered in 1964. The following comments from two visitors illustrates the extent to which the Museum is reaching its goals:

> "The Museum of Medical Progress . . . is unique in that it blends with the historical countryside and is situated on the ruins of Old Fort Crawford of 142 years ago. It leaves an everlasting impression on the visitor."
>
> MORRIS R. KEEN, M.D., Historian
> Suffolk County (New York) Medical Society

> ". . . needless to say, we all enjoyed our tour tremendously. No classroom health lesson could teach a fraction of the amount learned during our visit."
>
> LAURA CYR, Fifth Grade Teacher
> Harry Spence School
> La Crosse

On April 15, the site opens for its fifth full season with numerous improvements in the displays. Major among these is construction of a theater area within the Stovall Hall of Health, devoted to progress in medical and health education. Displays trace the development of medical education and the growing interest of the general public in health matters. Highpoint of the presentation features the "Transparent Twins" a unique audiovisual exhibit on basic anatomy, developed especially for the Museum as a part of the public education program of Wisconsin Physicians Service.

It can be accurately said that the Museum of Medical Progress and Stovall Hall of Health continues to grow in importance each year as a site of national significance in interpreting the progress of medicine to the general public.

The Foundation Executive Committee has considered various administrative rules and has adopted guidelines for student loans, the sale of memorabilia and artifacts, the acceptance of projects, procedures for requests from other organizations or individuals for project loans, and specific matters such as loaning the Bohrod paintings and the use of the "Transparent Twins." To enable administrative functions to be carried out more effectively, and because the number of services and projects of the Foundation have grown so rapidly, the office of Director of the Charitable, Educational and Scientific Foundation has been created. This is a full-time position occupied by Norman J. Salt, who has recently served the Society as Office Services Director.

The Foundation has received many artifacts from numerous contributors throughout the year, and has had collections presented by the family of the late LeRoy Armstrong, M.D., Past President of the Society. Aaron Bohrod has also donated another painting to the Foundation that is to become a part of the permanent collection of Medicine in Art.

The above represents only a small portion of the artifacts and memorabilia received during the past months. Attached is a listing of all monetary contributions made during the year of 1964, and it is hoped that a complete listing of all memorabilia received by the Foundation can be prepared for presentation at the October House of Delegates meeting.

Contributions to the Charitable, Educational and Scientific Foundation

BY MEMBERS OF COUNTY MEDICAL SOCIETIES

January 1, 1964—December 31, 1964

County	Number of Members	Number of Physicians Contributing	Total Amount of Contributions
Ashland-Bayfield-Iron	19	5	$ 290.00
Barron-Washburn-Sawyer-Burnett	33	4	95.00
Calumet	9	---	---------
Chippewa	24	3	30.00
Clark	14	1	10.00
Columbia-Marquette-Adams	31	6	190.00
Crawford	9	1	10.00
Dane	471	77	5,511.00
Dodge	48	5	120.00
Douglas	24	7	110.00
Eau Claire-Dunn-Pepin	93	10	170.00
Fond du Lac	79	13	205.00
Forest	5	---	---------
Grant	31	30	400.00
Green	41	8	630.00
Green Lake-Waushara	15	2	50.00
Iowa	11	1	25.00
Jefferson	36	9	175.00
Juneau	6	2	20.00
Kenosha	82	21	513.00
La Crosse	100	13	335.00
Lafayette	6	1	1.00
Langlade	17	3	35.00
Lincoln	14	5	80.00
Manitowoc	49	8	140.00
Marathon	69	17	270.00
Marinette-Florence	20	2	35.00
Milwaukee	1,373	118	3,876.00
Monroe	15	3	400.00
Oconto	9	2	15.00
Oneida-Vilas	28	7	110.00
Outagamie	88	7	105.00
Pierce-St. Croix	34	10	135.00
Polk	24	4	20.00
Portage	27	2	35.00
Price-Taylor	12	1	25.00
Racine	129	20	308.00
Richland	12	3	85.00
Rock	114	16	1,298.00
Rusk	5	1	40.00
Sauk	26	5	60.00
Sbawano	18	---	---------
Sbeboygan	78	11	133.00
Trempealeau-Jackson-Buffalo	24	3	120.00
Vernon	18	---	---------
Walworth	30	1	20.00
Waukesha	113	14	200.00
Waupaca	22	4	65.00
Winnebago	99	19	521.00
Wood	77	12	215.00
Brown	129	14	295.00
Door-Kewaunee	20	2	30.00
Ozaukee	18	5	110.00
Washington	30	4	145.00
	3,928	542	$17,816.00

BY COUNTY MEDICAL SOCIETIES

	Amount of Contribution
State Medical Society of Wisconsin	$ 7,860.00
Dane County Medical Society	29,301.04
Grant County Medical Society	4,425.65
Kenosha County Medical Society	1,000.00
Lafayette County Medical Society	1,500.00
Marinette County Medical Society	3,189.00
Ozaukee County Medical Society	100.00
Vernon County Medical Society	250.00
Woman's Auxiliary to the State Medical Society	979.00
Woman's Auxiliary to the Brown County Medical Society	25.00
Woman's Auxiliary to the Dane County Medical Society	10.00
Woman's Auxiliary to the Marathon County Medical Society	5.00
	$48,644.69

BY OTHER ORGANIZATIONS AND MISCELLANEOUS

American Cancer Society, Wisconsin Division	$ 174.00
Merck Sharp and Dohme Postgraduate Program	1,538.09
Wisconsin Heart Association	266.00
Eli Lilly and Company	100.00
Fred Pabst Foundation	500.00
Geyer, Morey, Ballard, Inc.	50.00
Hoffmann La Roche, Inc.	500.00
Kobler Company	100.00
Ross Laboratories	100.00
Smith, Kline & French Laboratories	550.00
Walgreen Drug Stores	50.00
Weiler Strang & Associates	100.00
Wisconsin Hospital Association	50.00
Wisconsin Life Insurance Company	100.00
Wisconsin Physicians Service	1,085.00
Wisconsin Radiological Society	100.00
Wisconsin Society of Anesthesiologists, Inc.	100.00
Northeastern Chapter of Wisconsin Academy of General Practice	25.00
Secretaries of North Central Conference	50.00
Clinic of Internal Medicine	100.00
Paul E. Goetz for Anna Friedrich	1,000.00
Miscellaneous	841.20
	$ 7,479.29
TOTAL	$73,939.98

BY PROJECTS

January 1, 1964—December 31, 1964

Donations—General	$ 9,784.45
Student Loans	4,557.00
Fort Crawford—Museum	4,695.25
Charitable—Disabled Physicians	9,336.00
Speakers Service	1,703.09
Teaching Clinics—Scientific	1,450.00
Coin Collection	2.00
Scientific Teaching—General	1,122.50
Other than CESF Projects	650.00
J. G. Crownhart Memorial	140.00
W. W. Hildebrand, Esquire, Memorial	130.00
Dane County Health Careers Loan Fund	29,126.04
Menominee County Educational Fund	3,000.00
Marinette County Health Careers Loan Fund	3,189.00
Grant County Health Careers Loan Fund	4,425.65
Woman's Auxiliary Indian Affairs	200.00
Woman's Auxiliary Health Careers	300.00
Woman's Auxiliary Project to be Determined	129.00
	$73,939.98

STATEMENT ON MEDICARE
by the
State Medical Society of Wisconsin

Medicare has now become the law of the land through the democratic processes of our country, processes of which we may all be proud. During debates upon the measure, the medical profession voiced its opposition, its reasons for that opposition and presented alternative proposals. That is a fundamental privilege of the democratic process, a privilege which all citizens must cherish and protect.

But now that Medicare is law, the State Medical Society of Wisconsin, through its members, will provide full measure of constructive leadership in its administration. Where we find improvement necessary, we will speak up. Where deficiencies become obvious, we will not hesitate to point them out. And where the law is effective, we will express our opinion on that as well.

Since this law is now a fact, it will require the kind of leadership that the medical profession, and only the medical profession, can provide. We will provide it. Nothing less than that could we do in good faith to our patients and in satisfaction of our professional and civic conscience.

Note: The philosophy expressed in this statement was authorized by the Council (Board of Trustees) and officers of the State Medical Society of Wisconsin, meeting in Madison, Sunday, August 1, 1965.

Actual authorship is that of *James C. Fox, M.D., La Crosse,* Chairman of the Council; *E. J. Nordby, M.D., Madison,* Vice-Chairman; *J. H. Houghton, M.D., Wisconsin Dells,* President of the Society; and *Frank E. Drew, M.D., Milwaukee,* President-Elect of the Society.

PROCEEDINGS OF HOUSE OF DELEGATES

ANNUAL MEETING • MAY 3, 4, 5, 1965 • MILWAUKEE

MONDAY EVENING SESSION

May 3, 1965

The House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, Wisconsin, on May 3, 4 and 5, 1965, convened at 7:10 p.m., Dr. Robert E. Callan, Speaker, and Dr. G. A. Behnke, Vice-Speaker, presiding.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

C. J. Strang, M.D., Barron, Chairman
H. F. Twelmeyer, M.D., Wauwatosa
M. V. Overman, M.D., Neillsville
E. D. Sorenson, M.D., Elkhorn
L. W. Schrank, M.D., Waupun

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

W. T. Russell, M.D., Sun Prairie, Chairman
G. W. Hilliard, M.D., Milwaukee
W. F. Henken, M.D., Racine
C. A. Grand, M.D., Ashland
D. J. Twohig, M.D., Fond du Lac

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

G. E. Collentine, Jr., M.D., Milwaukee, Chairman
B. P. Waldkirch, M.D., De Pere
D. R. Griffith, M.D., Eau Claire
C. J. Picard, M.D., Superior
H. M. Suckle, M.D, Madison

Speaker Callan: The report of the Credentials Committee will be withheld for a few minutes until the full anticipated attendance is here

APPROVAL OF 1964 INTERIM SESSION PROCEEDINGS

At this time a motion will be entertained to approve the record of proceedings of the 1964 Interim Session as published in the December 1964 WISCONSIN MEDICAL JOURNAL.

Dr. V. J. Burch (Racine): I so move.
(Motion seconded and carried.)

Speaker Callan: The Standing Rules of Procedure are stated on page 3 of the House of Delegates Calendar. Is it the pleasure of the House that these Rules be adopted as the standing rules of this session? These are the Rules under which we have operated for several years.

Dr. J. F. Walsh (Port Washington): I so move.
(Motion seconded and carried.)

■ REPORT OF THE PRESIDENT—May 1965

Dr. W. P. Curran (Antigo): For the past twelve months it has been my honor and pleasure to have served as your president. As usual, it is surprising how rapidly the time has passed. Some days the time passes quickly when one is busy doing the work he likes. In my case this has been true. Not all of the duties as president have bowled me over with pleasure, but all in all the experience has been a pleasant one, one that I would recommend to all of you as a crash program of education in matters of medical organization and legislation.

The course is a rigid one, requiring many hours of work both mental and physical and, I might add, financial; but the satisfaction that comes to one at the end of the course is gratifying.

Through association with the many people one meets, with the exchange of ideas and personalities, it is impossible not to end the year in a spirit of gratitude for all the good things that people do for you. Many problems were present before the State Medical Society of Wisconsin in May 1964, and many problems still exist. This is true in all organizations of a like kind. However, many of our ills have been treated and no longer are matters of great concern. Those that are still with us will be worked at with determination to solve them if at all possible, under the direction of your new and capable president, Dr. John Houghton. I know he will receive the same unselfish help from all of you that was tendered to me during this past year.

Socialistic care of the sick, by whatever name is given to the program, is apparently with us, and there will be a period of readjustment in the care of people under this program in the coming years. Much misunderstanding will be present, due in great part, I believe, to the lack of information of the average layman as to what he will receive in care, both in service and cost-wise. I believe that if all people who will come under this program had fully understood its mechanism, including some of our national representatives in Congress, this present dilemma would not exist.

Many people tried to inform the citizens about what the bill for medical care would do for them, the good as well as the bad. One of the most enlightening articles on this matter was written by Mr. James Spaulding, of the MILWAUKEE JOURNAL staff. I, as a practitioner of medicine, am grateful to him for his attempt to show the citizens the jungle into which they are being led.

No president can function adequately without help from his fellowmen and the home office. I am grateful to the many men and the committees of our Society for the aid they gave me this past year. I shall always be grateful to Dr. Bill Egan for the many lessons he taught me. Also, allow me to express my heartfelt thanks to our secretary, Mr. Charles Crownhart, and the entire staff, too numerous to call by name but so helpful to me on so many occasions during my term of office.

A year ago I asked you to bring men into our Society. I believe a great deal has been done in the past twelve months to bring about this fact. May all of us through factual information concerning the workers in our organization, keep it this way.

■ REPORT OF THE PRESIDENT-ELECT —May, 1965

Dr. J. H. Houghton's report appeared in the June 1965 issue of the WISCONSIN MEDICAL JOURNAL.

Dr. J. H. Houghton (Wisconsin Dells): Committee appointments are as follows:

To the Committee on Cancer: There are six terms expiring. I should like to reappoint G. A. Smiley, M.D., of Delavan; R. C. Glise, M.D., of Richland Center; R. C. Frank, M.D., of Eau Claire; G. I. Uhrich, M. D., of La Crosse; J. F. Brown, M.D., of Rhinelander, and J. J. Gramling, Jr., M.D., of Milwaukee.

A summary report of the House Proceedings, accompanied by pictures, appeared in the June issue of the WISCONSIN MEDICAL JOURNAL at page 236.

I should like to reappoint Doctor Smiley as chairman and reappoint Doctor Glise as vice-chairman.

To the Committee on Grievances: Three terms expire on this Committee. May I reappoint E. D. Sorenson, M.D. of Elkhorn; R. W. Mason, M.D., of Marshfield, and E. W. Mason, M.D., of Milwaukee. I should like to reappoint Doctor Sorenson to serve as chairman, and reappoint J. D. Leahy, M.D., Park Falls, to serve as vice-chairman.

To the Commission on Public Policy: There is one five-year term expiring, that of L. J. Kurten, M.D., of Racine, and I should like to reappoint him for another five-year term.

There are five three-year terms expiring. These men are section representatives. I should like to reappoint R. L. Gilbert, M.D., of La Crosse, from the Section on Internal Medicine; reappoint J. B. Durst, M.D., of La Crosse, from the Section on obstetrics and Gynecology; reappoint P. K. Odland, M.D., of Janesville, from the Section on Orthopedics; appoint A. D. Anderson, M.D., of Madison, from the Section on Surgery, and reappoint S. A. Freitag, M.D., of Janesville, from the Section on Urology.

In addition, two members have asked to be relieved of their duties on the Commission on Public Policy. They are R. G. Zach, M.D., of Monroe, and H. E. Oppert, M.D., of Viroqua. I wish to state here that we owe Doctor Zach a great vote of thanks for the work he has done on this Commission. Both terms expire in 1967. To fill these unexpired terms, I should like to appoint L. W. Schrank, M.D., of Waupun, and T. E. Henney, M.D., of Portage.

To serve as chairman of this Commission, I should like to appoint W. T. Russell, M.D., of Sun Prairie; and to serve as vice-chairman, C. F. Broderick, M.D., of Wisconsin Dells.

To the Commission on Scientific Medicine: There are two terms expiring. I should like to appoint J. A. Killins, M.D., of Green Bay, and R. A. Starr, M.D., of Viroqua. This Commission selects its own chairman.

To the Commission on Hospital Relations and Medical Education: Three terms expire on this Commission. I should like to reappoint M. V. Overman, M.D., of Neillsville, and A. J. Richtsmeier, M.D., of Madison, and appoint R. S. Galgano, M.D., of Delavan. I should like to reappoint G. B. Murphy, Jr., M.D., of LaCrosse, to serve as chairman of this Commission.

To the Commission on Public Relations and Communications: There are three terms expiring. I should like to reappoint C. J. Picard, M.D., of Superior, and appoint R. G. Hansel, M.D., of Baraboo, and R. R. Rueckert, M.D., of Portage. I should like to reappoint D. E. Dorchester, M.D., of Sturgeon Bay, to serve as chairman, and reappoint R. J. Botham, M.D., of Madison, to serve as vice-chairman.

Speaker Callan: Is there a motion to approve these appointments?

Dr. E. V. Stadel (Reedsburg): I so move.
(Motion seconded and carried.)

■ REPORT OF THE COUNCIL—May 1965

Dr. John M. Bell (Marinette): I am reporting to you as vice-chairman of the Council. I suppose all of you know that the chairman, Doctor Fox, is in LaCrosse. The rumor that he is in LaCrosse checking on the rooms he will need for next year's meeting is false. He was called back by an emergency situation.

Saturday night the Executive Committee of the Council met, and the Council itself met yesterday afternoon. As a result of these meetings there are several additional matters to report to the house. The following will be transmitted this evening:

(1) Certified financial statements by Donald E. Gill & Company for the State Medical Society and related organizations. These are in the form last requested by the Reference Committee on Reports of Officers.

(2) Resolution 5 by the Douglas County Medical Society relating to interim meetings of the House of Delegates. This is submitted by the Council without recommendation, but with the comment that, if favorably considered by the House, its provisions should be in conformance with the Constitution and Bylaws relating to meetings of the House.

(3) Report of the Commission on Hospital Relations and Medical Education. In reference to this report, the Council can report that it has approved as a model only the suggested agreement between a Wisconsin hospital and physician practicing an in-hospital specialty prepared by the Commission.

(4) Report 5-A which supplements the Handbook report of the Commission on Public Policy and includes later information on the status of public health measures in the Wisconsin Legislature.

(5) The Council introduced Resolution 14 at the interim session last October. It would amend Chapter XI, Section 3 of the Bylaws to include voluntary surrender of license as a circumstance whereby membership automatically terminates. It is reintroduced for action at this annual meeting.

In addition, the Council announces reelection of T. W. Tormey, Jr., M.D., as general chairman of the Commission on State Departments, and election of W. J. Egan, M.D., as vice-chairman. All division chairmen were reelected, namely, Drs. A. M. Hutter, H. A. Anderson, J. W. Nellen, John R. Evrard, C. A. Wunsch, H. W. Carey, P. A. Dudenhoefer, R. B. Windsor, J. C. H. Russell, and Meyer S. Fox.

The Council has offered cooperation with the State Department of Public Welfare, which has recently contracted with the U. S. Public Health Service to administer a federal program of health counseling to those who are not accepted by the armed forces for medical reasons. The Society's endorsement of the program has been requested, and the Council does so provided its administration is conducted in a manner that will not disturb normal patient-physician relationships.

Finally, the Council took pleasure last evening in presenting specially created awards to Drs. T. A. Leonard, F. J. Hofmeister, and G. S. Kilkenny, for devoted service in the maternal mortality studies of the Society since their authorization in 1951.

■ REPORT OF TREASURER—Year Ended December 31, 1964

Dr. F. L. Weston (Madison): In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years I am reporting to you here only on those funds which are the direct responsibility of the Treasurer, designated as the Society's "General Fund". Information on financial condition and income and expenditures of related activities of the Society is submitted to you separately, in

accordance with a recommendation made to you in October, 1963 by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A—Balance Sheet at December 31, 1964.

Schedule A-1—Reconciliation of Net Worth at December 31, 1964.

Exhibit B—Statement of Income and Expense—General Fund—Year Ended December 31, 1964.

The records of the State Medical Society of Wisconsin have been audited for the year 1964 by Donald E. Gill & Company, Certified Public Accountants. A representative of this firm is present and available for consultation during the course of this Annual Meeting.

Exhibit A

State Medical Society of Wisconsin
General Fund

Madison, Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS			
Cash—Approximately $82,000 of this amount is earmarked for: Membership Dues received in December, Prepaid 1965 Annual Meeting Exhibit Space Rentals, Accrued Payroll Taxes and other current payables as of 12/31/64		$100,356.17	
Accounts Receivable		1,002.59	
Due from Society Divisions—Current		16,978.97	
Due from Related Organizations—Current		16,875.88	
Guaranty Deposit		425.00	
Working Capital Advance—Wisconsin Medical Journal		5,929.47	
Furniture and Equipment	$37,348.07		
Less: Accumulated Depreciation	30,581.50	6,766.57	
Prepaid Expenses and Deferred Charges		17,376.48	
TOTAL ASSETS			$165,711.13
LIABILITIES AND NET WORTH			
Liabilities			
Accounts Payable		$ 7,632.92	
Dues—Suspense		301.90	
Accrued Payroll Taxes		23,182.17	
Prepaid Membership Dues		37,605.00	
Other Prepaid Income		13,800.00	
Accrued Expense		941.97	
Total Liabilities			$ 83,463.96
Net Worth			
Surplus—General Fund		$ 74,170.90	
Net Worth of Wisconsin Medical Journal		5,929.47	
Surplus Reserved for Section on Medical History		2,146.80	
Total Net Worth			82,247.17
TOTAL LIABILITIES AND NET WORTH			$165,711.13

Exhibit B

State Medical Society of Wisconsin
General Fund

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1964

INCOME		
Membership Dues	$317,290.40	
Dues—Section on Medical History	1,830.00	
Annual Meeting	27,732.22	
Administrative Services	2,400.00	
Investment	2,291.00	
Miscellaneous Income	2,040.66	
Gain on Disposal of Fixed Assets	105.14	
TOTAL INCOME		$353,689.42
EXPENSES		
Auditing and Accounting Consultation Services	$ 4,734.46	
Conference Expense	35,091.84	
Depreciation	2,628.92	
Grants and Appropriations	5,010.00	
Insurance—General	2,441.52	
Legal Services	20,749.00	
Legislative Retainer	8,900.00	
Office Supplies	1,734.06	
Outside Services	14,809.32	
Payroll	142,189.39	
Payroll Taxes and Employee Benefits	17,118.40	
Postage and Express	14,093.47	
Printing and Forms	22,142.95	
Promotion	10,628.41	
Rent—Central Office	36,660.00	
Rent—Other	6,253.69	
Resource Material	7,255.48	
Speakers Expenses	4,885.34	
Telephone and Telegraph	2,756.16	
Travel Expense—Staff	12,980.01	
Other Expenses	8,571.17	
Total	$381,633.59	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others	9,397.96	
TOTAL EXPENSES		372,235.63
EXCESS—EXPENSES OVER INCOME (TO NET WORTH)		$ 18,546.21

Schedule A-1

State Medical Society of Wisconsin
General Fund

Madison, Wisconsin

RECONCILIATION OF NET WORTH

Year Ended December 31, 1964

	Section on Medical History	Wisconsin Medical Journal	Reserve: Special Assessment	Unappropriated Society Surplus	Total
Balance—January 1, 1964	$ 1,123.50	$13,671.52	$23,205.70	$72,789.37	$110,790.09
Changes—1964	1,023.30	(7,742.05)	(2,254.66)	(19,569.51)	(28,542.92)
Total	$ 2,146.80	$ 5,929.47	$20,951.04	$53,219.86	$ 82,247.17
Transfer—1964	—0—	—0—	(20,951.04)	20,951.04	—0—
Balance—December 31, 1964	$ 2,146.80	$ 5,929.47	$ —0—	$74,170.90	$ 82,247.17

( ) Denotes Red Figure.

■ CERTIFIED CONSOLIDATED BALANCE SHEET December 31, 1964

State Medical Society of Wisconsin and Related Organizations, Madison, Wisconsin

March 31, 1965

State Medical Society of Wisconsin
330 East Lakeside Street
Madison, Wisconsin

Gentlemen:

We have audited the accounts of the State Medical Society of Wisconsin, a corporation, Madison, Wisconsin for the year ended December 31, 1964. Our examinations have included the General Fund of the Society and all other of the divisions within the Society's corporate structure, which are:

Wisconsin Medical Journal
Wisconsin Physicians Service
Military Dependents' Medical Care Plan of the U.S. Government in Wisconsin

Our audit reports on each of these divisions of the Society for the year ended December 31, 1964 are separately submitted.

Also, we have audited the accounts of all those separate organizations related by direct control to the State Medical Society of Wisconsin for the year ended December 31, 1964. These related organizations are:

SMS Realty Corporation
Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
Student Loan Fund of the State Medical Society of Wisconsin
Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

Our audit reports on all of these related organizations are separately submitted.

So that the financial condition of these various divisions and organizations at December 31, 1964 may be seen in consolidated form, we submit with this letter a Certified Consolidated Balance Sheet of the State Medical Society of Wisconsin and Related Organizations at December 31, 1964.

In addition we include with this letter the individual Balance Sheets at December 31, 1964 and Statements of Income and Expense for the year ended that date for each division and related organization.

Respectfully submitted,

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants
Madison, Wisconsin

State Medical Society of Wisconsin and Related Organizations
Madison, Wisconsin

CERTIFIED CONSOLIDATED BALANCE SHEET
December 31, 1964

ASSETS		
Cash	$1,012,586.64	
Current Receivables	673,074.68	
Invested Funds and Accrued Interest Receivable (Note 1)	5,308,138.79	
Long-Term Receivables	3,250.00	
Student Loans Receivable and Accrued Interest	107,844.05	
Land, Buildings, Equipment and Vehicles—Net Book Value (Note 2)	1,012,519.61	
Organization Expense	804.35	
Prepaid Expenses and Deferred Charges	62,099.80	
TOTAL ASSETS		$8,180,317.92

LIABILITIES, RESERVES AND CAPITAL		
Current Payables, Other Than Benefits	$ 105,227.61	
Mortgages and Debentures Payable	52,500.00	
Deposits Held	16,010.24	
Old Outstanding Checks	6,203.21	
Benefits Payable	2,670,000.00	
Unearned Income	1,810,091.21	
Reserves of Medical Care Plans	2,654,665.74	
Total Liabilities and Reserves	$7,314,698.01	
Net Worth of General Fund	82,247.17	
Capital of SMS Realty Corporation	261,348.35	
Restricted Principal of Funds	522,024.39	
TOTAL LIABILITIES, RESERVES AND CAPITAL		$8,180,317.92

CONTINGENT LIABILITIES	
Contractual Future Adjustment of Income Under Federal Employee Program	See Note 3
Federal Income Taxes	See Note 4

Notes one to six inclusive which follow are an integral part of this Balance Sheet.

NOTES

1. Invested funds shown above are included in some cases at book value and in others at market value. In the case of the Pension Plan values on the books are adjusted annually to market values in accordance with provisions of the Trust Agreement. In the case of Wisconsin Physicians Service, Securities are valued at those market values prescribed by the National Association of Insurance Commissioners, which were, in total, less than book value by $46,999.50. For all securities of Wisconsin Physicians Service, the market value determined by reference to closing or bid prices in financial publications at December 31, 1964 was less than book value by $44,840.12. The securities owned by the Charitable, Educational and Scientific Foundation are shown at book value, which was less than market value on December 31, 1964 by $227.55.

2. Fixed assets shown above at book value include those of the Charitable, Educational and Scientific Foundation, some of which are shown at appraisal values.

3. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the contract period which closed October 31, 1964 has not yet become final. Results of the succeeding period, which includes November and December 1964, will not be known for some time. Adverse results in total operations of the program could occasion an additional liability when this information is known.

4. The Internal Revenue Service has made an examination of the information returns which have been filed by the State Medical Society of Wisconsin. The Society was granted status as an exempt organization in a letter from the Internal Revenue Service dated April 8, 1939. Out of this examination the Internal Revenue Service has raised a question regarding imposition of a tax on net income of the Society's insurance operations. No final determination or proposal of a specific amount of tax has yet been made.

5. Certain payables and receivables between the State Medical Society of Wisconsin and its related organizations are eliminated from assets and liabilities above. These are:

State Medical Society of Wisconsin and Related Organizations
Madison, Wisconsin

CERTIFIED CONSOLIDATED BALANCE SHEET
December 31, 1964

Current Accounts	$ 21,383.38
Mortgage Loans	591,953.54
Leasehold Improvements (Shown as Reduction of Fixed Assets of SMS Realty Corporation)	25,500.00
Total	$638,836.92

6. The term, "Restricted Principal of Funds", in this Balance Sheet refers to the Net Worth of those organizations whose funds may be used solely for specifically designated purposes. There is no equity of the State Medical Society of Wisconsin in any of these funds. They are:

- Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
- Student Loan Fund of the State Medical Society of Wisconsin
- Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1964

	State Medical Society of Wisconsin	SMS Realty Corporation	Restricted Funds	Total
Balance January 1, 1964	$87,584.39	$239,570.87	$458,793.23	$785,948.49
Excess—Income Over Expense—1964	(18,546.21)	.....	.....	(18,546.21)
Increases in Fund Capital	20,951.04	21,777.48	63,231.16	105,959.68
Total	$89,989.22	$261,348.35	$522,024.39	$873,361.96
Decrease in Fund Capital	7,742.05	.....	.....	7,742.05
Balance December 31, 1964	$82,247.17	$261,348.35	$522,024.39	$865,619.91

CERTIFICATE

We have audited the accounts of the State Medical Society of Wisconsin, a Wisconsin corporation, Madison, Wisconsin and accounts of its related organizations for the year ended December 31, 1964. Our audit included all divisions of the Society within its corporate structure which are: General Fund, Wisconsin Medical Journal, Wisconsin Physicians Service, and Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin. It included also all those organizations related by direct control to the State Medical Society of Wisconsin which are: SMS Realty Corporation, a corporation; Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin, a corporation; Student Loan Fund of the State Medical Society of Wisconsin, a trust; and Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin, a trust. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Consolidated Balance Sheet, including the six notes which are a part of it, presents fairly the financial condition of the State Medical Society of Wisconsin and its related organizations at December 31, 1964, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ Donald E. Gill & Company
Certified Public Accountants

Madison, Wisconsin
March 31, 1965

The balance sheets and statements of income and expense for separate divisions and related organizations appear in the following order:

- State Medical Society of Wisconsin (General Fund)
- Wisconsin Medical Journal
- Wisconsin Physicians Service
- Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin
- SMS Realty Corporation
- Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
- Student Loan Fund of the State Medical Society of Wisconsin
- Employees Pension Plan and Trust Agreement of State Medical Society of Wisconsin

State Medical Society of Wisconsin

General Fund
Madison, Wisconsin
BALANCE SHEET
December 31, 1964

ASSETS			
Current Assets			
Cash		$100,356.17	
Accounts Receivable—General		699.59	
Accounts Receivable—Employees		736.74	
Due From Society Divisions		16,978.97	
Due From Related Organizations		16,367.37	
Guaranty Deposit		425.00	
Unexpired Insurance		553.96	
Total Current Assets			$136,108.80
Long-Term and Fixed Assets			
Working Capital Advance—Wisconsin Medical Journal	$ 5,929.47		
Furniture and Equipment—Cost Less Depreciation	6,766.57		
Total Long Term and Fixed Assets			12,696.04
Prepaid Expense and Deferred Charges			
Supplies and Forms Inventory		$ 6,366.09	
Deferred Expenses		10,232.42	
Total Prepaid Expenses and Deferred Charges			16,598.51
TOTAL ASSETS			$165,403.35
LIABILITIES, RESERVES AND CAPITAL			
Current Liabilities			
Accounts Payable		$ 8,267.11	
Dues Suspense		301.90	
Accrued Payroll Taxes		23,182.17	
Total Current Liabilities			$ 31,751.18
Deferred Income			
Prepaid Dues and Other Income			51,405.00
TOTAL LIABILITIES			$ 83,156.18
NET WORTH			
Net Worth of General Fund—January 1, 1964		$ 87,584.39	
Additions:			
Transfer of Special Assessment Funds (Note 2)		20,951.04	
Total		$108,535.43	
Deductions:			
Decrease in Working Capital Advance Wisconsin Medical Journal	$ 7,742.05		
Excess of Income over Expense (Deficit)	18,546.21	26,288.26	
TOTAL NET WORTH—December 31, 1964			82,247.17
TOTAL LIABILITIES, RESERVES AND CAPITAL			$165,403.35

Notes:
(1) Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.

(2) Action levying the Special Assessment in 1962 provided that any remaining balance after all costs related to the management survey were paid would revert to the General Fund. A reconciliation of this account for the year ended December 31, 1964 follows:

Balance—January 1, 1964		$ 23,205.70
Assessments Received		None
Total		$ 23,205.70
Expenses of Survey Paid	$ 2,254.66	
Transfer to General Fund	20,951.04	23,205.70
Balance—December 31, 1964		$ None

STATEMENT OF INCOME AND EXPENSE—GENERAL FUND

Year Ended December 31, 1964

INCOME		
Membership Dues—Current Year		$316,733.40
Membership Dues—Prior Years		557.00
Dues—Section on Medical History		1,830.00
Annual Meeting		27,732.22
Administrative Services		3,936.10
Interest Earned on Invested Funds		2,291.00
Miscellaneous Income		1,272.37
Gain on Disposal of Fixed Assets		105.14
TOTAL INCOME		$354,457.23
EXPENSES		
Auditing and Accounting Consultation Services	$ 4,734.46	
Association Dues	1,438.30	
Cafeteria Expense	1,183.65	
Conference Expense	35,091.84	
Depreciation	2,628.92	
Grants and Appropriations	5,010.00	
Insurance—General	2,441.52	
Legal Services—General	20,749.00	
Legislative Retainer	8,900.00	
Miscellaneous Expense	3,513.72	
Office Supplies and Expense	1,734.06	
Outside Services	14,809.32	
Postage and Express	14,093.47	
Printing and Forms	22,142.95	
Promotion	10,628.41	
Rent—Central Office	36,660.00	
Rent—Other	6,253.69	
Rental of Equipment	1,449.20	
Repairs and Maintenance of Equipment	815.35	
Resource Material	7,255.48	
Speakers Expense	4,885.34	
Personal Property Tax	406.99	
Telephone and Telegraph	2,756.16	
Travel Expense—Staff	12,980.01	
Payroll	142,189.39	
Personnel Services	531.77	
Insurance—Employees	4,218.12	
Retirement Plan Contribution	9,253.09	
Payroll Taxes	3,647.19	
Total	$382,401.40	
Less: Expenses Charged Out for Services to Others (See Note)	9,397.96	
TOTAL EXPENSES		373,003.44
Excess—Income over Expense (Deficit)		($ 18,546.21)

STATEMENT OF INCOME AND EXPENDITURES—SPECIAL ASSESSMENT FUND

Year Ended December 31, 1964

INCOME		
Special Assessments Received		$ None
EXPENSES		
Conference Expense	$ 1,290.78	
Legal Services	500.00	
Office Supplies and Expense	74.46	
Outside Services	280.91	
Travel Expense	40.55	
Telephone and Telegraph	21.35	
Refund of Prior Year Income	43.75	
Miscellaneous Expense	2.86	
TOTAL EXPENSES		2,254.66
Excess of Income over Expense (Deficit)		($ 2,254.66)

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS		
Current Assets		
Cash in Bank	$ 6,195.41	
Accounts Receivable—Advertisers	9,373.97	
Accounts Receivable—Other	281.17	
Due From Wisconsin Physicians Service	72.00	
Copyright Deposits	76.00	
Postage Deposits	52.75	
Unexpired Insurance	8.82	
Total Current Assets		$16,060.12
Fixed Assets		
Furniture and Equipment	$ 1,386.74	
Less: Accumulated Depreciation	674.73	
Total Fixed Assets		712.01
Deferred Charges		
Mailing Envelope Inventory	$ 298.48	
Deferred Blue Book Expense	257.50	
Total Deferred Charges		555.98
TOTAL ASSETS		$17,328.11
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 3,260.95	
Due State Medical Society of Wisconsin	8,137.69	
Total Liabilities		$11,398.64
Capital—January 1, 1964	$13,671.52	
Less: Excess of Expense Over Income—1964	7,742.05	
Capital—December 31, 1964		5,929.47
TOTAL LIABILITIES AND CAPITAL		$17,328.11

Note: The capital of the Wisconsin Medical Journal is carried as a working capital advance among the assets of the State Medical Society of Wisconsin General Fund.

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1964

INCOME		
Advertising Income	$38,392.61	
Subscriptions and Supplemental Income	893.00	
State Medical Society Appropriation	3,000.00	
Reprint Income	4,135.57	
Gain on Disposal of Fixed Assets	30.00	
TOTAL INCOME		$46,451.18
EXPENSE		
Direct Payroll	$ 7,135.44	
Printing	35,418.06	
Cuts	1,221.82	
Postage	1,638.37	
Rent	840.00	
Reprints	3,770.97	
Advertising Discount	15.05	
Copyright Expense	48.00	
Telephone	47.81	
Office Supplies and Expense	328.55	
Accounting Services	220.30	
Advertising Commissions	201.75	
Depreciation	153.04	
Insurance—Employees	385.39	
Insurance—General	45.58	
Legal Services	900.00	
Miscellaneous Expense	457.75	
Outside Services	37.36	
Workmen's Compensation	6.30	
Printing and Forms	258.16	
Social Security Tax	342.65	
Federal Unemployment Tax	30.62	
Wisconsin Unemployment Tax	38.26	
Retirement Plan Contribution	651.00	
Uncollectible Item	1.00	
TOTAL EXPENSE		54,193.23
EXCESS OF INCOME OVER EXPENSE		($ 7,742.05)

( ) Denotes Red Figure.

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS		
Current Assets		
Cash	$ 763,623.83	
Due from Agents	1,071.26	
Due from Plan Administrator—Federal Employee Program	13,483.52	
Due from Medicare—Current	2,311.05	
Premiums Receivable	587,983.21	
Refunds Receivable	13,285.91	
Other Current Receivables	9,894.29	
Unexpired Insurance	2,907.28	
Current Investments and Accrued Interest (Note 1)	4,916,305.94	
Total Current Assets		$6,310,866.29
Long-Term and Fixed Assets		
Advance to Medicare	$ 100,000.00	
Mortgage Loans Receivable	591,953.54	
Real Estate, Held as Investment—Cost Less Depreciation	21,078.01	
Improvements, Equipment and Automobiles—Cost Less Depreciation	120,883.45	
Total Long-term and Fixed Assets		833,915.00
Deferred Charges		
Supplies and Forms Inventories	$ 33,004.56	
Other Deferred Expense	3,749.65	
Total Deferred Charges		36,754.21
TOTAL ASSETS		$7,181,535.50
LIABILITIES AND RESERVES		
Current Liabilities		
Accounts Payable	$ 32,067.07	
Due Related Interests—Current	13,920.89	
Due Plan Administrator—Federal Employee Program	5,073.00	
Accrued Expenses	7,488.60	
Old Outstanding Checks	6,203.21	
Premium Deposits	16,010.24	
Subscriber Benefits Payable	2,670,000.00	
Provision for Merit Rating Credits	18,075.54	
Total Current Liabilities		$2,768,838.55
Deferred Income		
Premiums Not Earned	$1,756,831.21	
Unearned Administrative Income	1,200.00	
Total Deferred Income		1,758,031.21
TOTAL LIABILITIES		$4,526,869.76
Reserves		
Reserves—January 1, 1964	$2,877,262.29	
Less: Special Items (Note 4)	293,438.96	
Balance	$2,583,823.33	
Add: Excess—Income over Expense—Year 1964	72,821.76	
Total	$2,656,645.09	
Less: Transfer to Reserve for Market Values of Securities	1,979.35	
Reserves—December 31, 1964		2,654,665.74
TOTAL LIABILITIES AND RESERVES		$7,181,535.50
CONTINGENT LIABILITIES		
Federal Employee Program Income		See Note 2
Federal Income Tax		See Note 3

Notes

(1) Securities are shown above at market value on December 31, 1964 in accordance with valuation data prescribed by the State of Wisconsin Insurance Department for this purpose. Following is a comparison of book value, market value as shown above, and market value using reputable financial publications at December 31, 1964.

Book Value	$4,905,799.50
Market Value—Insurance Method Above	$4,858,800.00
Market Value—Financial Publications	$4,860,959.38

(2) Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the contract period which closed October 31, 1964 has not yet become final. Results of the succeeding period, which includes November and December, 1964, will not be known for some time. Adverse results in total operations of the program could occasion an additional liability when this information is known.

(3) The Internal Revenue Service has made an examination of the information returns which have been filed by the State Medical Society of Wisconsin. The Society was granted status as an exempt organization in a letter from the Internal Revenue Service dated April 8, 1939. Out of this examination the Internal Revenue Service has raised a question regarding imposition of a tax on net income of the Society's insurance operations. No final determination or proposal of a specific amount of tax has yet been made.

(4) There were certain developments in 1964, subsequent to the closing and reporting date for 1963 operations, which affected prior periods. Wisconsin Physicians Service has treated two items arising from these developments as special items, and has separated them from 1964 operations in its accounts. These two items are set forth in the Statement of Income and Expense and Special Items which follows.

STATEMENT OF INCOME AND EXPENSE AND SPECIAL ITEMS

Year Ended December 31, 1964

INCOME			
Earned Premium Income			$15,383,784.02
Less: Merit Rating Credits			24,717.55
Net Earned Premium Income			$15,359,066.47
Benefits Incurred			13,795,995.88
Net Underwriting Gain			$ 1,563,070.59
EXPENSES			
Agents Expense		$ 80,437.04	
Joint Plan Expense—Federal Employee Program		524.01	
Insurance Examination Expense		2,574.75	
Actuarial Services		4,204.20	
Auditing and Accounting Consultation Services		7,449.00	
Association Dues		10,675.51	
Automobile Expense		1,214.28	
Cafeteria Expense		4,734.61	
Conference Expense		14,497.67	
Consultation Services		13,412.50	
Amortization of Leasehold Improvements		2,267.60	
Depreciation		19,481.21	
Field Service Expense		10,143.67	
Grants and Appropriations		1,080,00	
Insurance—General		8,998.54	
Insurance—Employees		31,197.84	
Legal Services		24,300.14	
Medical Consultant Services		4,943.75	
Miscellaneous Expense		17,630.44	
Office Supplies and Expense		12,783.13	
Outside Underwriting Services		7,941.55	
Payroll		851,052.51	
Sales Incentive Bonus		5,205.13	
Postage		46,172.61	
Printing and Forms		44,969.45	
Promotion		128,001.89	
Rent—Offices		149,262.67	
Rental—Data Processing Equipment		89,455.93	
Repairs and Maintenance—Equipment		4,102.51	
Resource Material		987.46	
Retirement Plan Contributions		24,601.07	
Personal Property Tax		2,475.42	
Payroll Taxes		28,943.06	
Telephone and Teletype		16,356.50	
Travel and Auto Rental Expense—Staff		63,024.85	
Total		$1,735,102.50	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others		28,216.59	
Net Administrative Expense			1,706,885.91
Net Gain (Loss) from Operations			($ 143,815.32)
Investment and Other Income			
Interest Earned		$ 202,136.20	
Dividend Income		5,585.25	
Amortization of Premiums and Discounts		6,186.16	
Rental Income		960.00	
Total		$ 214,867.61	
Less: Investment Consultation Expense	$ 2,948.38		
Securities Safekeeping Expense	1,716.67		
Rental Property Expense and Taxes	1,168.68		
Loss on Disposal of Securities	347.21	6,180.94	
Net Investment Income		$ 208,686.67	
Other Income	$10,214.06		
Less: Loss on Disposal of Fixed Assets	2,263.65		
Net Other Income		7,950.41	
Total Investment and Other Income			216,637.08
Excess—Income over Expense, Before Special Items			$ 72,821.76
Special Items			
Merit Rating Refund for 1963, in Excess of Amount Provided at December 31, 1963		$ 81,438.96	
Major Medical Claims Incurred, in Excess of			

Amount Provided at December 31, 1963	212,000.00	
Total Special Items (Expense)		$ 293,438.96

( ) Denotes Red Figure.

MILITARY DEPENDENT'S MEDICAL CARE PLAN OF THE U. S. GOVERNMENT IN WISCONSIN

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1964

ASSETS		
Current Assets		
Cash in First National Bank, Madison, Wisconsin	$ 49,100.86	
Cash in and In Transit To Dakota National Bank, Bismarck, N. D.	20,043.65	
Due From U. S. Government, Office for Dependents' Medical Care	32,110.06	
Due From State Societies—Sub Contracts	1,412.34	
Suspended Claims	65.00	
TOTAL ASSETS		$102,731.91
LIABILITIES		
Current Liabilities		
Due Wisconsin Physicians Service—Current	$ 2,311.05	
Due North Dakota State Medical Association	420.86	
Total Current Liabilities	$ 2,731.91	
Advances		
Advanced Funds—Wisconsin Physicians Service	$100,000.00	
TOTAL LIABILITIES		$102,731.91

STATEMENT OF INCOME AND EXPENSES
Year Ended December 31, 1964

INCOME		
U. S. Government, Office for Dependents' Medical Care		$ 23,377.94
Indiana State Medical Association		2,958.87
Iowa State Medical Society		1,520.97
Minnesota State Medical Association		2,247.12
South Dakota State Medical Association		482.01
TOTAL INCOME		$ 30,586.91
EXPENSES		
Accounting Services	$ 329.34	
Office Supplies and Expense	206.42	
Payroll	13,412.60	
Postage and Express	1,545.45	
Printing and Forms	2,131.08	
Rent	180.00	
Telephone Service	241.68	
Travel Expense	202.24	
Overhead Expense	6,972.67	
Machine Service Expense	5,270.85	
Conference Expense	90.00	
Miscellaneous Expense	4.58	
TOTAL EXPENSES		30,586.91
Balance		$ None

SMS REALTY CORPORATION

Madison, Wisconsin

BALANCE SHEET
December 31, 1964

ASSETS			
Current Assets			
Cash		$ 20,393.40	
Accounts Receivable		411.76	
Due From Wisconsin Physicians Service		5,007.61	
Due From CES Foundation		8.40	
Investments		111,474.69	
Cafeteria, Fuel and Supplies Inventories		2,316.73	
Accrued Interest Receivable		1,060.71	
Unexpired Insurance		932.86	
Total Current Assets			$141,606.16
Fixed Assets			
Land, Buildings, Improvements, Equipment and Automobiles		$964,157.83	
Less: Accumulated Depreciation		213,469.58	
Net Book Value		$750,688.25	
Less: Leasehold Improvements Paid By Wisconsin Physicians Service		25,500.00	
Total Fixed Assets			725,188.25
Intangible Assets			
Organization Expense			644.35
Deferred Charges			
Prepaid Licenses			50.00
TOTAL ASSETS			$867,488.76
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable—Trade		$ 4,938.02	
Due State Medical Society of Wisconsin		1,748.82	
Accrued Sales Tax		.03	
Mortgage Notes Payable—Current		6,914.98	
Total Current Liabilities			$ 13,601.85
Long-Term Liabilities			
Debenture Payable		$ 7,500.00	
Mortgage Notes Payable	$591,953.54		
Less: Current Portion	6,914.98	585,038.56	
Total Long-Term Liabilities			592,538.56
TOTAL LIABILITIES			$606,140.41
NET WORTH			
Investment of State Medical Society		$150,245.96	
Donated Capital		3,300.00	
Reserves		82,161.07	
Unappropriated Surplus		25,641.32	
TOTAL NET WORTH			261,348.35
TOTAL LIABILITIES AND CAPITAL			$867,488.76

RECONCILIATION OF NET WORTH
Year Ended December 31, 1964

	Balance 1/1/64	Increase From Operations	Balance 12/31/64
Investment of State Medical Society	$150,245.96	$	$150,245.96
Donated Capital	$ 3,300.00	$	$ 3,300.00
Reserves			
For Repair and Maintenance	$ 22,595.38	$ 2,925.54	$ 25,520.92
For Return on Investment	39,520.00	5,000.00	44,520.00
For Funding Appreciation	8,324.53	3,795.62	12,120.15
Total	$ 70,439.91	$ 11,721.16	$ 82,161.07
Unappropriated Surplus (Deficit)	$ 15,585.00	$ 10,056.32	$ 25,641.32
TOTAL NET WORTH	$239,570.87	$ 21,777.48	$261,348.35

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1964

INCOME		
Rental Income	$185,660.00	
Cafeteria Income	29,719.29	
Dividend Income	1,200.00	
Interest Income	2,249.57	
Other Income	987.87	
TOTAL INCOME		$219,816.73
EXPENSES		
Legal Services	$ 1,192.50	
Accounting Services	574.75	
Managerial Services	5,185.17	
Janitorial and Part-time Help	19,060.64	
Internal Accounting	999.96	
Messenger and Switchboard Operator	7,608.75	
Telephone and Telegraph	10,952.44	
Gas and Light	8,870.32	
Water and Sewer	1,467.31	
Heat	4,863.14	
Building Supplies	3,972.85	
Repairs and Maintenance	6,574.46	
Auto Expense	774.54	
Insurance	2,038.10	
Depreciation, Net of Amortization of Improvements	36,452.71	

Interest Expense	29,341.56	
Property Taxes	20,333.60	
Payroll Taxes	1,213.51	
Group Insurance	1,095.16	
Retirement Plan Contribution	1,231.26	
Cafeteria Expense	29,719.29	
Rental Property Expense	392.10	
Miscellaneous Investment Expense	20.00	
Other Expenses	4,055.48	
Loss on Disposal of Fixed Assets	49.65	
TOTAL EXPENSES		198,039.25
Excess—Income over Expense		$ 21,777.48
Transfer to Reserve for Repairs and Maintenance	$ 2,925.54	
Transfer to Reserve for Return on Investment	5,000.00	
Transfer to Reserve for Funding Appreciation	3,795.62	
Transfer to Unappropriated Surplus	10,056.32	
Total		$ 21,777.48

Note: The items shown above representing payroll and related costs are paid by the State Medical Society of Wisconsin as the employer. SMS Realty Corporation has no employees and is not an employer, but reimburses the Society for amounts of payroll, payroll taxes and related costs.

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INCORPORATED OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS			
Current Assets			
Cash on Hand		$ 11,051.52	
Cash in Banks		28,027.47	
Pledges Receivable		600.00	
Accrued Interest Receivable		1,014.55	
Unexpired Insurance		364.73	
Total			$ 41,058.27
Long-Term Assets			
Notes Receivable Student Loans	$107,043.71		
Less: Interest of Student Loan Fund in Notes Receivable	1,705.00	$105,338.71	
Other Loans Receivable		3,250.00	
Common Stocks—As Valued at Time of Donations (Market Value $18,490.70)		18,263.15	
Savings and Loan Certificates		40,000.00	
Certificates of Deposit		11,000.00	
Total			177,851.86
Fixed Assets			
Land, Buildings and Equipment—Net			137,891.32
Intangible Assets			
Organization Expense			160.00
Deferred Charges			
Expenses Deferred			1,023.89
TOTAL ASSETS			$357,985.34
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable		$ 2,049.24	
Due Related Interests		14,626.95	
Accrued Interest Payable		103.12	
Total			$ 16,779.31
Deferred Income			
Advance Receipts—1965 Programs		$ 575.00	
Unallocated Contributions		80.00	
Total			$ 655.00
Funded Liabilities			
Mortgage Notes Payable			45,000.00
TOTAL LIABILITIES			$ 62,434.31
Capital			
Restricted Capital		$250,902.47	
Unrestricted Capital		44,648.56	
Total Capital			295,551.03
TOTAL LIABILITIES AND CAPITAL			$357,985.34

Note: Fixed Assets above are shown at values determined by appraisals of real estate and equipment and cost of additions purchased or constructed.

RECONCILIATION OF CAPITAL ACCOUNTS

Year Ended December 31, 1964

	Restricted	Unrestricted	Total
Balance—January 1, 1964	$226,531.53	$57,896.33	$284,427.86
Less: Special Items (Exhibit D)	36,200.00		36,200.00
Balance	$190,331.53	$57,896.33	$248,227.86
Add: Capital Contributions (Exhibit C)	46,432.69		46,432.69
Excess Income over Expense—Year 1964	2,322.11	(1,431.63)	890.48
Transfers	11,816.14	(11,816.14)	
Balance—December 31, 1964	$250,902.47	$44,648.56	$295,551.03

STATEMENT OF CAPITAL CONTRIBUTIONS

Year Ended December 31, 1964

Student Loan Projects	
General Contributions	$ 3,482.00
Dane County Medical Society	29,126.04
Marinette-Florence County Medical Society	3,189.00
Grant County Medical Society	4,425.65
Albert Popp, M. D.	1,210.00
Menominee County Educational Fund	3,000.00
Total—Student Loan	$44,432.69
Cunningham Memorial Fund	1,000.00
Elvehjem Memorial Fund	1,000.00
Total Capital Contributions	$46,432.69

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1964

INCOME		
Contributions		
Restricted as to Use	$31,225.28	
Not Restricted	3,730.00	
Memorial Contributions	3,164.51	
Total Contributions		$38,119.79
Other Income		
Fees for Scientific Teaching Activities	$ 1,776.00	
Museum Admissions	7,229.90	
Sales of Souvenirs and Jewelry, Less Cost	344.11	
Interest Income	1,805.53	
Dividend Income	1,700.08	
Miscellaneous Income	83.80	
Total Other Income		12,939.42
TOTAL INCOME		$51,059.21
EXPENSES		
Museum of Medical Progress	$25,920.54	
Charitable Assistance	550.00	
Costs of Equipment for Loan	14.00	
Specialized Stamp Collection	15.65	
Specialized Coin Collection	397.04	
AMA-ERF	620.00	
Scientific Teaching	5,204.61	
Teaching Resources in Health Education	2,500.00	
Menominee County Survey	5,484.52	
Netsuke Collection	300.00	
Cunningham Memorial Lecture	225.80	
J. G. Crownhart Memorial	204.40	
Contributions Transmitted	150.00	
General Administration	8,582.17	
TOTAL EXPENSES		50,168.73
Excess Income over Expenses		$ 890.48
SPECIAL ITEMS		
Pledge Recorded as Income in 1963, Reversed in 1964		$36,200.00

Note: The foundation now classifies separately contributions received for projects in which capital is loaned or invested. Such contributions are not included above for 1964.

STUDENT LOAN FUND OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS	
Interest in Notes Receivable—Student Loans	$1,705.00
LIABILITIES AND CAPITAL	
Liabilities	$ None
Student Loan Fund Capital	1,705.00
TOTAL LIABILITIES AND CAPITAL	$1,705.00

Statement of Income and Expense

Year Ended December 31, 1964

INCOME	
None	$ None
EXPENSE	
None	None
Excess—Income over Expense	$ None

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT OF STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin

BALANCE SHEET

December 31, 1964

ASSETS			
Current Assets			
Cash in Bank			$ 13,794.33
Accounts Receivable			956.11
Dividends Receivable			165.00
U. S. Government Securities—At Cost		$ 53,994.08	
Adjustment to Market		(620.09)	53,373.99
Federal Agency Bonds—At Cost		$ 5,028.13	
Adjustment to Market		(34.38)	4,993.75
Corporate Bonds—At Cost		$ 37,785.88	
Adjustment to Market		545.37	38,331.25
Common Stocks—At Cost		$ 79,273.74	
Adjustment to Market		2,935.01	82,208.75
Investments in Savings and Loan Associations			30,000.00
Accrued Interest Receivable			912.35
Total Current Assets			$224,735.53
Deferred Charges			
Deferred Investment Expense			32.83
TOTAL ASSETS			$224,768.36
LIABILITIES AND PRINCIPAL			
Liabilities			$ None
Principal of Fund—January 1, 1964		$172,660.37	
Employer Contributions	$37,109.00		
Employee Contributions	14,843.59		
Total Contributions	$51,952.59		
Fund Earnings (Exhibit B)	9,444.00		
Total Increases		61,396.59	
Total Before Deductions		$234,056.96	
Payment on Death of Employee	$ 5,240.32		
Payments to Terminating Employees	2,675.70		
Forfeited Portion of Accounts	1,372.58		
Total Decreases		9,288.60	
Principal of Fund—December 31, 1964			224,768.36
TOTAL LIABILITIES AND PRINCIPAL			$224,768.36

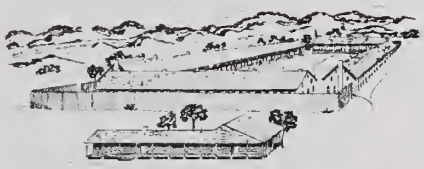
Note: Securities are shown above at market value as required by the trust agreement. This treatment has been followed consistently since inception of the trust.
( ) Denotes Red Figures.

STATEMENT OF FUND EARNINGS

Year Ended December 31, 1964

INCOME		
Dividends on Common Stocks	$2,304.75	
Dividends on Savings and Loan Investments	1,200.00	
Total Dividends		$ 3,504.75
Interest Earned		3,656.58
Gain in Market Values of Securities		3,021.50
TOTAL INCOME		$10,182.83
EXPENSE		
Investment Counsel Expense		738.83
NET FUND EARNINGS		$ 9,444.00

It is much easier to understand, and graphically illustrate the advances of medicine with actual displays of authentic equipment and materials used by physicians of the past.



1830 (C) 2nd Fort Crawford and Military Hospital

1961 Military Hospital structure restored and made into the Museum of Medical Progress

Future Plans for the Medical Museum

Any effort that brings such illustration to the public is bound to have the advantageous effect of making them more aware of the role that medicine may, at one time or another, play in their lives.

There's Still Time To Visit

MUSEUM OF MEDICAL PROGRESS
AND STOVALL HALL OF HEALTH

Open until November 1

Prairie du Chien — So. Beaumont Road

■ REPORT OF THE SECRETARY—May 1965

Mr. Charles Crownhart (Madison): Times seem to change. We are two stories up on the podium, with no steps, and it is equally as difficult to get down as it is to get up.

I have spoken to the House for twenty-one or twenty-two years. I have had mixed emotions as I have talked to you. A couple of years ago I was a little emotionally upset by a report that came in to you. Other times I have talked to you on legislation, federal and state; and I suppose in view of what is happening in LBJ-land I might appear before you somewhat disconsolate, but it happens that I am not.

I am a state secretary who is looking ahead a few years with satisfaction and with a high degree of confidence that the Federal Government has not and is not going to let the people down. That is due in large part to some wise congressmen, and more specifically Congressman Byrnes, who lives in Green Bay.

Hospital coverage for the 65-year-and-older group apparently is going to become socialized and provided as a commodity, but as far as I can tell at the present time medical care is recognized for what it really is—the personal service that is not to be price-tagged and put on the shelf of a store as though it were a commodity.

Congressman Byrnes in part has brought that about, and developments today in the Senate would appear to support my conclusion that American medicine is recognized as the finest that exists in the civilized world. Not even LGB, whom I respect as a politician, is going to change quality in the philosophy that he is going to provide a greater quantity, because quality and quantity in American medicine must be more or less identical.

Despite some reactions to the contrary, I personally remain in strong support (as I am sure you do) of the leadership at 535 North Dearborn Street, Chicago. It must represent a wide geographical difference of opinion, philosophy and economy, It is doing a really fine job, sometimes not to my liking and, I am sure, sometimes not to yours. But "Bing" Blasingame and the leadership of the AMA are devoted—not devoted to American medicine but devoted to the promotion of American medicine for the benefit of the American people.

For a long time it has been said in Wisconsin (and I think it should be said nationally) that there is nothing for the benefit of medicine unless it is for the benefit of the people. The two interests are identical. When we assert ourselves in public health insurance, it is not for the advancement of the doctor of medicine but is for the protection and promotion of public health.

In the Wisconsin Legislature there have been those Assemblymen up to the moment who, new to legislative ways, apparently feel that they may be the Board of Regents of the University of Wisconsin and can grant academic degrees by legislative fiat. This is a strange mechanism of education. Doctorate degrees, Master degrees, Bachelor of Science degrees, have been the action of academic and not legislative authority, and it is going to be a sad day if the Wisconsin Legislature arrogates to itself the power to grant an academic degree.

I do not myself possess a Doctor's degree, although having witnessed several graduation ceremonies and having heard those receiving the degrees of Doctor of Medicine being publicly announced, I have a feeling that were I more loyal to my own profession of the law I would see that they had equivalent treatment and were also announced publicly by name.

I am concerned that this type of thing would come about; but I have faith that the Senate, composed of thirty-three men, possibly more seasoned and less new to the legislative process, will not arrogate to themselves the granting of an academic degree to people with poor (even if adequate) training in a very limited field.

So, I come before you tonight, as I hope I come before my fellow executives, saying that medicine has not lost but has gained stature. The American people are convinced, and I am convinced that they are. They are convinced that medical care is not a system to be socialized, but a system to be praised and utilized for delivering what it can—the best medical care in the country and in the world.

As I reach this age of twenty-two or twenty-three years of service in your behalf, I congratulate you, a profession that has delivered well and that will continue to do so in the future.

It is my duty to add to the report of the Council the necrology report, the deaths of *Drs. C. W. Lockhart*, of Mellen; *M. J. Reuter, Sr.*, of Milwaukee; *E. H. Mensing*, of Milwaukee; *Bruno Warschauer*, of Milwaukee; *J. P. Canavan*, of Neenah, and C. M. Wahl, of Spring Green. (Names in italic indicate Society membership.)

(Silent standing tribute.)

■ REPORT OF THE STATE HEALTH OFFICER May 1965

Dr. Carl N. Neupert (Madison): I think you know this is a special event for me. This is my last time to appear before you. Even very special, cherished privileges come to an end. And so it is with me and the annual report to you on the affairs of the State Board of Health. In a few weeks this Golden Ager will be relieved of the many responsibilities he has carried for all these years as state health officer. That load will be transferred to the capable shoulders of Dr. E. H. Jorris, whom you know and with whom you have worked over the years also.

When one approaches the end of the road he is tempted to prolong the opportunity to speak by way of reminiscing, as some older people do. But don't worry; the invitation was, as usual, to address the House of Delegates briefly. I intend to be just that.

I am very grateful to you and your predecessors, if there be some among you who have been here less than the twenty-two years I have tried to meet this responsibility, for an effective, cooperative relationship between private practitioners of medicine and those of us in public service. We are indebted to you for much help, and we are dependent upon you as are people generally for tremendous advancements in scientific medicine, in health care, and in the prevention of disease for fuller, more healthful living.

We have had some differences of opinion on occasions in the past, as is to be expected. Sometimes I wonder if you would have welcomed more vigorous protests somewhat like a colleague in another state has come forth with. His state society likes him and his approach, and they work well together. We haven't done badly. The results speak for themselves.

Let me touch briefly on two current matters. As predicted last year, there was a rather extensive revision of the Nursing Home Rules that became effective on last July 1. One county society protested to the Board about some of the new requirements that call for professional nurse service in the skilled nursing home; but the problems are gradually being worked out, and overall changes have been quite beneficial. Revisions of these new rules are under study and will be accomplished as soon as possible in a few months.

The other problem has to do with requests from hospitals and physicians for permission to put "clean" GYN cases on obstetrical units of hospitals,

and to modify the regulation that requires the presence of the physician while oxytocics are being administered.

The Joint Commission on Accreditation of Hospitals has recently announced its change in position relative to the use of maternity rooms, and the regulation on administration of oxytocics is about to be reviewed also. A qualified ad hoc committee has been authorized by the Board to give these matters study and to come up with considered recommendations. So, one or both of these regulations may well be modified in the not-distant future.

There are other aspects of matters of joint interest that could be included in a report of the affairs of the State Board of Health; but you have much work before you, my time is up, and you know we will work together to solve problems in the best public interest.

■ REPORT OF THE EXECUTIVE SECRETARY OF THE STATE BOARD OF MEDICAL EXAMINERS—May 1965

Dr. T. W. Tormey (Madison): The Board of Medical Examiners continues to function in the interests of the general public as well as those of the medical and paramedical groups over which it has general supervision.

You will recall that cooperative discussions were held with the medical educators and hospital superintendents a year ago, concerning an annual $10 fee for resident physicians who qualified for the required licensure. A bill has been prepared and introduced in the Legislature to cover this subject. It provides for a $10 annual fee, renewable up to five years and applicable to the customary full license fee provided in the statutes. At this time there is no special reason to believe that this bill will not pass.

We all hope it will aid in accomplishing the purpose for which it was proposed, namely, attracting more hospital resident physicians to whom payment of the regular fee at one time was declared a hardship and a deterrent to accepting positions in Wisconsin.

We do not have special limited or institutional licenses such as are issued in some other states. Another type of limited or special license that we feel is indicated is one to cover the qualified individual who spends two or three weeks as a camp physician each summer. A number of licensed practicing doctors from other states inquire concerning their obligation if they donate their time to such camp coverage.

Again this year, a proposed bill to create a Central Licensing Agency was drafted and introduced in the Legislature. Under this proposal an appointed commissioner would have general supervisory control over the clerical, investigative, and financial functions of some two dozen or so licensing agencies. I am sure that the objections to such a situation were many and varied at the numerous informational conferences held with representatives of the agencies involved. This idea has been instituted in some states and has not been an altogether successful operation. I am informed that an amendment to the Constitution permitting this was put down by the Senate after it was adopted by the Assembly.

For some time past the Board has offered complimentary copies of the annual Register to what were considered needful purposes, above and beyond the required statutory distribution. Because this cost an estimated $600 to $800 each year, and because the obviously unjustified requests were increasing, a bill was introduced and passed allowing us to make a nominal charge of $1 for requested copies beyond our statutory obligation.

Because of the increased requests for the help of foreign graduate physicians in our public and medical communities, we requested and obtained legislative permission to accept fifty such selected applicants a year. This is an increase of twenty-five over the number we were permitted to license each year previously. We still have 300 or more inquiries a year about licensure from foreign graduates, so our field of selection is broad. Our quota is about 80 per cent filled for this year. Objections to this group are minimal, and I feel that, by and large, they are warmly received by colleagues and public alike.

As has been my custom in the past few years, I will briefly summarize what has happened to the 156 foreign graduate physicians licensed since January 1958:

75 are still in their original location.
29 never did settle in Wisconsin.
17 left the State.
31 moved to another location in the State.
3 have died.
1 license was surrendered.

Last year a total of 302 licenses were issued—

67 by written examination.
235 after reciprocity interviews.
Of this total, 6 were females.

26 investigations of complaints were carried out in 1964, including:

8 MD.s.
4 D.O.s.
11 quacks.
1 Masseur.
1 Physical Therapist.
1 Chiropractor.

To date the registration for 1964 includes:

4,535 M.D.s in State.
1,417 M.D.s out of State.
236 D.O.s (total)
540 Physical Therapists (total)
179 Podiatrists (total)

The overall total is 6,907 individuals.

While there are other matters with which we have been concerned, I believe those above will give you an indication of the scope and activity of the Board.

■ REPORT OF THE ACTING DEAN—MARQUETTE UNIVERSITY SCHOOL OF MEDICINE—May 1965

Dr. John S. Hirschboeck (Milwaukee): I am really speaking here tonight in the place of Dr. Gerald Kerrigan, who succeeded me as Dean, although he still has the title of Acting Dean. I hope it won't be much longer before he will have the full title of Dean. Doctor Kerrigan is in Philadelphia and asked me to make the report for the Marquette University School of Medicine.

What I am really going to give tonight, though, is not really his report but mine. It is not a report of the official Board of the Medical School. What I say may seem a little doom-like to some, but on the other hand what I really intend to convey to all of you tonight is the prospects of something I think really important for all of us in the medical profession in the State.

It is a pleasure to once again address the House of Delegates of the State Medical Society of Wisconsin, not only because it provides the occasion to meet alumni and friends of our Medical School but also because it gives Marquette University School

of Medicine an opportunity to make known to the medical profession of our State matters of importance to all of us.

It is encouraging to know that the number of applicants seeking admission to American medical schools is increasing. The trend away from medicine which recently greatly concerned us seems to have been reversed. In addition, the postwar "baby boom" is providing us with an ever-increasing number of applicants.

The Marquette University School of Medicine processed 1,192 applications for the class which we accepted last September. The Admissions Committee reviewed these applications and offered acceptances to 181. One hundred two students accepted the offer and registered. (One of these students is a part-time student.) The intellectual attainment as measured by the college grades and Medical College Admissions Tests scores for this group, and also for the group which is now being accepted for September 1965, is very good. We have, indeed, fine human resources with which to build the future of our profession. It is the obligation of the medical schools to form these young men and women into the future leaders of all of the health professions and transmit to them our heritage of service and science suffused with compassion and social consciousness.

You will recall that I did not meet with you last May. At that time I was occupied in directing a study of the future needs of the Marquette University School of Medicine. The challenge arising from the rapid growth of medical science and development, the increase in our population, the expansion of our economy, and the steady growth of government influence in health care and medical practice must be accepted by the medical schools. The Marquette University School of Medicine has had to define and measure its many opportunities for growth, and at the same time weigh these against problems which, in some ways, are overwhelming.

I would like to enumerate the pertinent observations which have come to me out of the Medical School Planning Project.

First, the opportunities.

1—The Marquette University School of Medicine has ample patient resources for clinical training. The size of the third- and fourth-year class could readily be enlarged to 150 or even more students providing, of course, supporting faculty and physical facilities would be available.

2—Metropolitan Milwaukee is undeveloped as a medical referral center. Except for the Veterans Hospital, only 2 per cent of hospitalized patients come from outside of metropolitan Milwaukee. For its size Milwaukee lags far behind comparable cities in the utilization of its resources to operate a regional medical center. Medical services and hospitals available in the Milwaukee area are not being used fully for medical education and research.

3—The Marquette University School of Medicine has an energetic, hard-working, well-trained core of young faculty members and departmental chairmen who are eager to create a superb medical school and provide the staff for the operation of an outstanding medical center.

And now, the problems:

1—The School is experiencing operating deficits which, unless satisfied, will soon force the School into bankruptcy. In other words, we will be seriously encroaching upon our assets if this continues.

2—The administrative and management interrelationships between the Marquette University School of Medicine and the Milwaukee County institutions, the Veterans Hospital and other affiliated institutions, including Marquette University itself, are complicated, inefficient and, in some instances, wasteful.

3—Voluntary health insurance, Kerr–Mills legislation and Public Welfare are depending more and more upon the Marquette University School of Medicine. Unless a way is found to compensate the Medical School for this cost, the Marquette University School of Medicine will not be able to survive.

In resolving these problems in the light of our opportunities, I suggest to the medical profession of our State the following propositions:

1—That the medical profession support the expansion of medical education in Milwaukee.

2—That the medical profession endorse collaboration between the Marquette University School of Medicine and the University of Wisconsin Medical School in planning for this expansion of medical education in Wisconsin. (I might say here that the presidents of the two Universities have agreed that we should plan together, and I think out of this should come a very well defined approach to how we can meet some of these problems in medical education.)

3—That the operating budget of the Marquette University School of Medicine must be balanced, and that all sources of income, except tuition, must be increased and new sources of income must be found.

4—That the faculty of the Marquette University School of Medicine should be expanded to accommodate larger classes in the third and fourth year, and that facilities, including a University hospital, clinic, and research buildings, should be built on the grounds of the county institutions to accommodate additional faculty and provide additional research and service.

5—That a way be found to bring about close collaboration between the Marquette University School of Medicine, Milwaukee County institutions, and other educational, medical and hospital resources, including the University of Wisconsin Medical School, in order to provide an efficient medical center administration to accommodate an expansion of undergraduate medical education in the third and fourth years.

In conclusion, it seems to me that although the people of Wisconsin and the medical profession of our State are facing, along with the Marquette University School of Medicine, some important decisions, I am confident that all of us will work together to bring about the changes required to provide Wisconsin with the best in medical care and health service.

■ REPORT OF THE ACTING DEAN—UNIVERSITY OF WISCONSIN MEDICAL SCHOOL —May 1965

Dr. James F. Crow (Madison): Much of what I am going to say will echo what Doctor Hirschboeck has just said, and many of the statements about the two schools are the same.

The University of Wisconsin has experienced the same rise in the number of applicants for a fixed number of positions as has Marquette. We too are facing the fact that we have far more good applicants than we can accept. I, as is Doctor Hirschboeck, am facing parents of good men who

could not be admitted to the Medical School because of the number of available spaces not being enough, including a substantial number of physicians.

It is my very strongly held opinion that the State of Wisconsin must somehow increase the number of medical students that it trains in its institutions.

I am aware, as you are, of the large number of people going into medical practice now who are graduates of foreign medical institutions. I am strong for an exchange of brains and manpower between one nation and another, but I think this should be a two-way street, not a one-way street, and the richest country in the world can afford to educate its own doctors and not have to rely on the brains of the doctors in the rest of the world to supply this need.

As I said, we have an increasingly large number of medical students applying, despite the fact that medical students are not being subsidized to anything like the extent that graduate students ordinarily are. As all of you are aware, most graduate students now have some sort of support. Hardly any medical students do.

One thing that the University of Wisconsin needs (and Marquette too, from my discussion with Doctor Hirschboeck) is more adequate scholarship funds and more adequate loan funds. The AMA Loan Fund is not too much of a help. It has an interest rate not greatly different from that of commercial banks. What students need, in my opinion, are scholarship and loan funds with a subsidy element at least at a very low interest rate.

The University Medical School has been growing in the past few years. It has added a number of good staff. The ones who are most important are the new departmental members in Pharmacology, a greater trend for full-time staff members in the Surgery Department, some additions in the Medical Department, and a new man in the History of Medicine, Doctor Monti, to replace Doctor Ackerknecht, well known to many of you.

The University has had excellent support from a legislative committee during the past year in endorsing its long-range building program. One element of this which will interest many of you, the Library, will get under way in a few weeks.

The DeBakey report and the various other kinds of reports on medical education and medical care, in particular the discussions about the cancer, stroke and heart centers, are very clear about one thing, namely, the great responsibility that is placed on the medical schools for the education of doctors in the State, not only before they become doctors but also afterward; and I hope along with Doctor Hirschboeck that the two schools can work cooperatively in developing this kind of program.

Just as Milwaukee has a large clinical center, a large clinical population, Madison has some shortage in this respect; but the University of Wisconsin has immense resources in the chemical and biological sciences related to medicine, not only in the preclinical faculty but also in the University as a whole.

I hope that ways will be found to increase the productivity of our medical schools—ways that are consistent not only with increasing numbers but also with maintaining the kind of quality that we have. I too am proud of American medical practice and medical standards, but I don't think we can rest completely on our laurels. I am just as impressed as you are, I believe, with the fact that although we have gone a long way, we still have quite a way to go. I am distressed by the fact that the infant mortality in the United States is still considerably behind that of many countries in Western Europe, and I won't be content with the fact that we have done the best we can until this country, with the highest living standard, can also have the lowest mortality rates.

REPORT OF THE WISCONSIN CHAIRMAN, AMA–ERF—May 1965

Dr. P. B. Blanchard (Cedarburg): Each year, as Wisconsin's chairman for AMA–ERF, the American Medical Association's Education and Research Foundation, it is my pleasure to present grants to the two medical schools in our State. These grants represent contributions from physicians, their families, and friends of medicine throughout the country.

More than $1,300,000 is being distributed by AMA–ERF to medical schools in the country this year. Since its Funds for Medical Schools program began in 1951, the AMA–ERF has made more than $15,000,000 in such grants.

I think it is important to note that these grants are completely unrestricted. The Deans may use them in the way they feel the contributions will best benefit their individual medical school.

Contributors to AMA–ERF for this program may designate a specific school to receive their gifts, or they can give without designation. In the latter case, their contributions are distributed equally among all approved United States medical schools.

And so, at this time it is my privilege to present to Acting Dean James F. Crow, of the University of Wisconsin Medical School, this check for $11,415.06. This represents $7,747.47 in designated gifts plus your participation in undesignated contributions.

To Dr. J. S. Hirschboeck, of the Marquette University School of Medicine, it is my privilege to present this check for $18,992.65. This represents $15,325.00 in designated gifts plus your participation in undesignated contributions.

REPORT OF THE PRESIDENT, WOMAN'S AUXILIARY—May 1965

Mrs. John J. Satory (La Crosse): As Eve was made of Adam's rib, so too the Woman's Auxiliary to the State Medical Society of Wisconsin was organized as a helpmate.

No county auxiliary can be organized unless the county medical society requests its organization. After organization, the Society should recognize it as an alliance and seek its help in the many ways that this report will show. It is true that many of these projects were done through suggestions from our national and State organizations, but there are many "local" opportunities by which the county society can compliment its auxiliary by asking its help.

When I went into office a year ago, I called upon my co-officers and chairmen to help make this the best year ever. The yardstick may be in figures with the dollar sign—as so much of today is measured—or it may be in numbers of membership, or pounds of benevolent drugs collected, or in your personal interpretation.

Last year Mrs. James, my admired predecessor, gave you a comprehensive report on projects, and an aim "to set a path of sound and continued growth." We have continued those projects and added a few with that aim. You may interpret the report:

For AMA–ERF: $6,606, an increase of $414 to date. This money was raised through memorials, sale of stationery, bracelet charms, decks of playing cards, dinner dances, cocktail parties, waist band measurements, and so on.

CES Foundation: Until this year, CESF received financial support from our budget, but this year it became a working project in the sale of Christmas cards. The project was set up last year and executed this year, with the result of $741.50 profit to the Auxiliary; $300 of this is designated for scholar-

ships for students in medically allied careers, in addition to $250 allotted from our budget for student loans; thus, a total of $550.

Two hundred dollars of the card sales goes to another CESF department, Indian Affairs. This was a new project and a very enthusiastically accepted one. We relied on the Menominee County Health Survey published by the State Medical Society. Because of the need for health education, it was arranged with the Menominee County Nurse to initiate a Red Cross training program on Home Nursing and Maternal-Child Care. The class was attempted, but interrupted because of the severe winter and lack of transportation. It is now to be reactivated. Our Indian Affairs Chairman visited Menominee County eight times, meeting with the County nurse, with Red Cross personnel, local officials, and with representative Menominees, in addition to attending seven meetings of Friends of Menominees, Inc., and participated in two all-day hearings on the Anti-Poverty Bill as it relates to the Menominees.

Many good used books were collected by Grant, Rock and Brown Counties. Barron–Washburn–Sawyer–Burnett Auxiliary and Waukesha County sent generous checks with which to purchase new books for the newly established Menominee County Public Library. Please note this includes several county auxiliaries of fifteen to eighteen membership. An auxiliary is never too small to contribute!

Those of you who remember figures will probably want to know what became of the other $241.50, since only $500 of the card sale profit has been accounted for. This being a woman's organization, we have as yet not decided how to spend it.

Community service by doctors' wives is almost unbelievable. I don't know when they find time to wear their chinchilla or exchange Cadillac for Continental! (This, of course, the public image.) They participate in the operation of blood bank, tuberculosis and diabetes mobile units; Cancer Day programs; all the health-related fund drives; hospital expansion fund drives; hospital auxiliary projects; visiting nurse service; family service; leper bandages; safety operation Quick Check; disaster preparedness; disaster nursing; Red Cross; mentally retarded; mentally ill; school bus disaster; flood disaster; YWCA; civil rights; Indian relief; community services fair; Boys School; serve on Committees for Aging, Foundation for the Blind; Meals on Wheels; immunization; supplying AMA posters and pamphlet racks. The list is actually endless.

To be specific, our State Community Service Chairman set up a pilot project in Homemaker Service in La Crosse County (since that is where she lives). This entailed many meetings with many groups and organizations, this in itself being good public relations. For further information on this, please refer to page 23 in your March issue of the WISCONSIN MEDICAL JOURNAL, "Your Auxiliary Reports."

Our Child Health Chairman wrote a booklet about the importance of play in hospitals, entitled, "When Patients are Children." This is to be printed and ready for distribution under the sponsorship of the Bureau of Maternal and Child Health of the State of Wisconsin. Another new project under this chairmanship is the "Block Mother Plan." Letters were sent to presidents of Parent-Teacher groups throughout the State, explaining the plan and offering Auxiliary aid for the fall of 1965.

Doctors' families were so healthy this year that they had enough sample medicine left over to supply International Health with 1,202 pounds plus 62 cartons, which were not weighed. These were sent to World Medical Relief. The Catholic Mission Board received sheets, shirts, and drugs.

A barrel of drugs was sent to Karo, Africa. Other supplies were sent to the Norbertine Fathers and Queen of Peace Monastery at Lake Geneva, Wisconsin, for foreign distribution.

Sixty pounds of medical journals were sent to the World Medical Association. Individuals gave support to Project Hope. International hospitality participation was reported by eleven counties.

Legislation used to be a deadly word as far as Auxiliary members were concerned, but not now! Our members have responded by making themselves heard on local, state and national levels. Speeches on Eldercare, Kerr–Mills, and Medicare were given to various groups such as hospital guilds, church groups, study groups, and so on.

The Legislative Roundup, sent out by the AMA, is of tremendous help, as is the Legislative Report Letter from your state office. I might insert here that a man in our State Legislature several days ago, in discussing the chiropractors' bill, stated that there are too few doctors active in politics or giving active support to a candidate. This man, fortunately, is on our side.

Safety legislation too has involved our response, and stressed education. Eighteen counties report activity in safety, especially gun safety, and babysitting.

In mental health we again supported Christmas projects and volunteer work with the mentally ill. A most forward step in personal contact was that members of two county auxiliaries entertained patients in their homes as a preparatory step for them to go back into the community.

Health Careers groups are active in thirty-one counties, and ten set up Career Days with speakers representing various fields related to medicine. Tours of hospitals, nursing, and medical schools were conducted. Eleven thousand dollars was raised for nursing scholarships. This does not include the $200 nursing scholarship fund in our State budget, making a total of $11,200. This is all in addition to CESF and AMA–ERF and, of course, late reports. One county reported sending jointly with the county medical society $15,000 to CESF for loans to students of that county. You may contend most of this money comes out of the husbands' pockets, but you must admit the women have a way of getting it out of the pocket and putting it to use!

The foregoing report honors the national theme, "Better Health, Better World."

Another achievement on the State level is that of obtaining the cooperation of all county auxiliaries to adjust to having spring election of officers in order to establish better continuity and liaison between state and county chairmen and officers.

In regard to membership, we followed last year's pattern of sending letters to unorganized counties, urging membership-at-large where organization was not feasible. We have asked county society presidents and councilors to help us with membership increases in organized counties, and as a result we have just over 1,900 members.

We have two areas about to organize; and with a special request from those county medical societies, namely, Wood and Ashland counties, I believe we can have auxiliaries there next fall.

Two county auxiliaries were salvaged when it became apparent that they were short on officers. We lost one county auxiliary through lack of local leadership and interest. As a result, we have thirty-two active county auxiliaries.

I visited all but seven counties. Several of these were scheduled, but weather did not permit going. The smaller the membership, the more important the visit. I also traveled 6,720 miles by car in the State, often accompanied by Mrs. Wolf or another Board member. I attended the Illinois and Michigan

State conventions and the AMA at San Francisco and the midyear conference in Chicago.

I feel very deeply that without the wonderful cooperation of our staff secretary, Leona Chesemore, in many, many ways, this would be a lesser report. At any time that I asked for anything in information or supplies, the personnel of the state office was most cooperative.

We recognize many of you here tonight as loyal supporters of Auxiliary activities. For this support we are most grateful. I trust something in this report has appealed to all of you.

It has been a wonderful, challenging year for me. A very special course on self help was given at 1404 Main Street, La Crosse, and the family came through beautifully. They, too, deserve my gratitude.

A very "first," to my knowledge, is that the State Society President's own last page in the WISCONSIN MEDICAL JOURNAL gave recognition to the Woman's Auxiliary. It has indeed given us a warm glow, and over 1,900 of us give Doctor Curran a large "thank you."

I should now like to introduce next year's President, Mrs. Frederick Wolf, who will be installed Thursday morning.

REPORT OF CREDENTIALS COMMITTEE

Speaker Callan: At this time we will have the report of the Credentials Committee. This Committee is composed of Drs. W. D. Hamlin, Mineral Point, Chairman; Ann Roethke, Milwaukee, and C. E. Koepp, Marinette.

Dr. W. D. Hamlin (Mineral Point): At this first session of the House of Delegates of the State Medical Society of Wisconsin, May 3, 1965, the Committee on Credentials has verified the registration of 78 delegates and 14 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate delegate who are unable to attend: Dr. R. G. Frantz of Waukesha, and Dr. William G. Richards of Dodge.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 92, representing 45 county medical societies and 10 Sections, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

SUPPLEMENTARY REPORT OF CREDENTIALS COMMITTEE

Doctor Hamlin: We have a supplemental report of the Credentials Committee for this first session of the House of Delegates.

In addition to those delegates already registered and reported by the Committee on Credentials, 5 delegates and 2 alternate delegates have registered and are entitled to vote.

I move that this attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 99, representing 47 county medical societies and 10 Sections, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

Speaker Callan: The Speaker would like to comment on the attendance of 99 out of a possible 114 delegates, the attendance of representatives of 47 out of 54 county societies, and the attendance of Section delegates from 10 of the 14 Sections of the State Medical Society. This is a very, very fine attendance.

REFERRAL OF REPORTS AND RESOLUTIONS

We come now to the referral of reports. So that the delegates may be advised as to which reference committee will hear the various reports and resolutions submitted, this announcement is made. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same reference committee.

Reference Committee on Reports of Officers

Report No. 3—Commission on Scientific Medicine.
Report No. 4—Committee on Military Medical Service.
Report No. 6—Report of the Council and the Supplemental report of the Council, with certain exceptions listed below which will be referred to the Reference Committee on Resolutions.
Report No. 7—Secretary.
Reports of the President, President-Elect, Treasurer, and President of the Woman's Auxiliary.

Reference Committee on Reports of Standing Committees

Reports Nos. 1 and 1-A through H—Commission on State Departments.
Resolution No. 4 by Brown County Medical Society.
Report No. 5 and Supplement 5-A—Commission on Public Policy.

Reference Committee on Resolutions

Resolutions Nos. 1, 2 and 3.
Two constitutional amendments printed on page 4 of the Calendar, one dealing with special sessions of the House of Delegates and the other dealing with terms of Councilors.
Report No. 2—Commission on Medical Care Plans
Report No. 8—Ad hoc Committee on Redistricting.
Resolution No. 14—Introduced by the Council in October 1964 and reintroduced at this session.
Resolution No. 5—Supplemental report of the Council, which report you will receive during the recess.

ELECTION OF COMMITTEE ON NOMINATIONS

(The districts were polled and the following were nominated as members of the Nominating Committee from their respective districts:)

First District	L. W. Schrank
Second District	Morris Siegel
Third District	R. N. Allin
Fourth District	W. D. Hamlin
Fifth District	E. C. Quackenbush
Sixth District	D. J. Twohig, Jr.
Seventh District	E. P. Rohde
Eighth District	C. E. Koepp
Ninth District	E. C. Glenn
Tenth District	L. O. Simenstad
Eleventh District	C. J. Picard
Twelfth District	P. G. LaBissoniere
Thirteenth District	E. F. Castaldo

Speaker Callan: You have heard the nominations. The Chair will entertain a motion that these nominees constitute the Nominating Committee.

Dr. E. D. Sorenson (Elkhorn): I so move.

(Motion seconded and carried.)

NEXT YEAR'S ANNUAL MEETING

Secretary Crownhart: Next year we will meet in La Crosse. This will be our last meeting in Milwaukee for at least two years. Unlike the Braves, I hope we will be warmly welcomed back when we

come, and I hope you will make the Milwaukee meeting the best we have had in any number of years.

I hope you will all plan to go to La Crosse. In due course the staff will announce some plans, including a special train out of Milwaukee, we hope, going to La Crosse, which will not be flooded in 1966. We have the assurance of the delegation that this will be true!

Speaker Callan: Is there a motion for adjournment?

Doctor Sorenson: I so move.

(Motion seconded and carried.)

(Meeting adjourned at 9:15 p.m.)

TUESDAY EVENING SESSION

May 4, 1965

The House of Delegates reconvened at 7:40 p.m., Dr. Robert E. Callan, Speaker, and Dr. G. A. Behnke, Vice-Speaker, presiding.

REPORT OF CREDENTIALS COMMITTEE

Doctor Hamlin: The Committee on Credentials has verified the registration of 64 delegates and 14 alternate delegates entitled to vote at this session of the House of Delegates. Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend: R. G. Frantz, M.D., for Waukesha and Theodore Rowan, M.D. for Dodge.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 78, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Re: Commission on Scientific Medicine

Dr. C. J. Strang (Barron): Your Reference Committee on Reports of Officers reviewed the report of the Commission on Scientific Medicine (No. 3) and wishes to compliment the Commission on its efforts in postgraduate medical education. Your Reference Committee feels that the traditional county society meeting is a good forum for disseminating medical knowledge, and that the Commission should not be discouraged in its efforts to promote this through the Speakers Service. Even though the audience at times may be small, certainly the reaching of some is better than none at all.

Your Reference Committee recommends acceptance of the Commission's report, and I so move.

(Motion seconded and carried.)

Re: Committee on Military Medical Service

Your Reference Committee has reviewed the report of the Committee on Military Medical Service (No. 4) and recommends its acceptance. I so move.

(Motion seconded and carried.)

Re: Council

The Reference Committee reviewed the report of the Council (No. 6) and portions of the supplementary report referred to it.

It recommends approval of the format as outlined by the Council for the La Crosse meeting in 1966.

It further agrees with the recommended disposition of Resolution 1, originally introduced by the Fond du Lac County Medical Society in October 1963, that it be tabled.

The Reference Committee reviewed the financial statements transmitted with the supplementary report of the Council and urges that they be studied in detail by each delegate, as they are a source of much information on operations of the Society. However, we recommend that in the future they be distributed at least four weeks in advance of the meeting.

I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Commission on Hospital Relations and Medical Education

Your Reference Committee reviewed the report of the Commission on Hospital Relations and Medical Education, also transmitted in the supplementary report of the Council. It notes that the Town and Gown conferences were well received, and strongly encourages their continuation.

Your Reference Committee recommends acceptance of the report as submitted. I so move.

(Motion seconded and carried.)

Re: Secretary's Report

Your Reference Committee reviewed the written report of the Secretary (No. 7) and his comments to the House at the first session. It was heartened by his optimism concerning the future of medicine. The Reference Committee would like to compliment the Secretary and encourage him in his efforts in our behalf. I so move.

(Motion seconded and carried.)

Re: President's Remarks

The remarks of President Curran were noted by the Reference Committee, and we believe the Society should record its gratitude for his fine leadership during the past year. I so move.

(Motion seconded and carried.)

Re: President-Elect's Address

The address by the President-Elect was reviewed, and your Reference Committee was impressed by its scope. It would particularly like to commend Doctor Houghton on his suggestions concerning the development of voluntary insurance programs to fill the gaps left by the current federal legislation for those 65 and over. I so move.

(Motion seconded and carried.)

Re: Treasurer's Report

The report of the Treasurer was studied, and the Reference Committee recommends its acceptance. I so move.

(Motion seconded and carried.)

Re: Woman's Auxiliary

Your Reference Committee was very much impressed by the aims and accomplishments of the Woman's Auxiliary as reported by Mrs. Satory. They have certainly earned an expression of gratitude by the State Medical Society. I so move.

(Motion seconded and carried.)

Doctor Strang: I now move adoption of this report as a whole.

(Motion seconded and carried.)

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Re: Commission on State Departments

Dr. W. T. Russell (Sun Prairie): Your Reference Committee on Reports of Standing Committees has reviewed the report of the Commission on State Departments, which is designed to coordinate the work of the ten Divisions reporting to it.

Re: Division on Aging

Your Reference Committee recommends acceptance of report 1-A from the Division on Aging, and agrees that the Division should continue its work in the field of nursing home accreditation and also its interest in community-based versus hospital-based coordinated home-care programs.

Your Reference Committee concurs with the recommendation that the Division on Aging conduct a workshop devoted exclusively to the problems of reemployment of the retired, and that it sponsor a one-day workshop on the medical aspects of nursing home care. I move acceptance of the report.

(Motion seconded and carried.)

Re: Division on Visual and Hearing Defects

Your Reference Committee also reviewed report 1-B from the Division on Visual and Hearing Defects, and commends the Division for its position, stating that physicians should be concerned with the physical impairment of vision rather than with the resulting visual disability when evaluating specific cases. Your Reference Committee recommends acceptance of this report. I so move.

(Motion seconded and carried.)

Re: Division on Nervous and Mental Diseases

In reviewing report 1-C from the Division on Nervous and Mental Diseases, your Reference Committee would like to emphasize that the work of the Division in the field of proposed community mental health programs is vital to all physicians.

The Reference Committee concurs with the Division in recommending that the Mental Health Advisory Committee of the State of Wisconsin should at all times have adequate physician representation.

The Reference Committee also recommends that the House of Delegates go on record supporting proposed legislation that would authorize welfare departments to reimburse a psychiatrist hospitalizing a welfare patient in a psychiatric ward in a private hospital.

After hearing testimony from various members of the Division, your Reference Committee recommends that additional staff assistance be provided to the Division on Nervous and Mental Diseases to assure comprehensive representation in the vast number of private and governmental programs being carried on in the field of mental health. Your Reference Committee, however, does not feel it wise to establish the precedent of designating full-time individual staffing for any particular function of the Society.

I move acceptance of this portion of the report of the Reference Committee.

Dr. B. P. Waldkirch (De Pere): I would like to give some of the reasons why Brown County has introduced its motion, which will be brought up as the next item in this report. I would like to discuss it now because I think it is appropriate at this point.

Brown County recommended, as the next resolution mentions, that a full-time staff man be assigned to this Division to carry on its work. I realize (and objection to this procedure has been repeatedly brought to our attention) that this sets a precedent and that everybody else is going to want a private secretary to carry on their work. We realized this when we introduced the resolution. However, we feel that this work is so important that the disadvantage of setting such a precedent must be accepted in order that this Division may do its work properly.

The work that this Division is doing is in the field of mental health, but the precedents that are being set in the field of mental health are going to affect all of medicine. There is only a handful of psychiatrists who can carry on this work. There are, I am told by the member of the Division who is from our County Society, that there is a tremendous amount of paper work to go over, and it has to be adjusted. These men are just not able to go through all this work. Doctor Lorenz said he had gotten 25 pounds of literature from the State of Wisconsin that he was supposed to read in order to get the background information on which to form intelligent opinions. He has a private practice. He has associates who expect him to do his amount of work in his practice, and he just doesn't have the time to do that much research work.

Someone has to sift the important things from the unimportant so that the medical men can concentrate on the important projects. All of this has to be done by someone, otherwise it is not going to be done at all. The meetings they go to are well represented by social workers, psychologists and social planners, and much of the planning that is being done does not have the benefit of medical thinking merely by default because there are no medical men who attend those meetings.

It is all very well to say that staff coverage will be increased; but if staff coverage is not done by one single individual, the man doing the work of the Division will not be knowledgeable enough and will not have enough information to do a good job. The Division presumably has had staff coverage all along, yet the work is not being accomplished in a manner they find useful. Therefore, we would like to again urge that this Division be given a man who will have enough time to become knowledgeable in this field.

I do not think Brown County wishes to oppose this motion at this time, although we have not caucused and I cannot speak for the other delegates. However, I think it is highly important that the staff coverage provided for this Division be by one individual who can form adequate background knowledge of it and who will be useful to the Division.

We are certain to come back to this House again at our next opportunity if we are informed that the Division is not getting adequate support. I think the work the Division is doing is so important that everything that can possibly be given to them in the way of assistance by the Society should be provided. This is the least we can do.

Dr. F. D. Cook (Green Bay): I don't wish to belabor the point, but I do think it was unfortunate that all the members of the House could not be present this morning to hear the discussion. I think all those present learned something from it.

I would like to ask that each one of us take a very serious look at the report in more detail, because I think the House would find it quite a revelation. The point of view that we in Brown County took was that this is for not only one Division but for every physician in the State of Wisconsin who practices medicine.

(Motion made and carried.)

Re: Resolution 4

Doctor Russell: Your Reference Committee also studied resolution 4 from the Brown County Medical Society, which asks that the State Medical Society engage the services of a competent, full-time staff man to devote his time to representing medicine's views in the rapidly developing mental health programs and planning, and that the State Medical Society, if necessary, increase its dues to provide the cost of this position as per the financial estimate of the Division on Nervous and Mental Diseases.

In view of the recommendations concerning the report of this Division, your Reference Committee recommends rejection of this resolution by the House. I so move.

(Motion seconded and carried.)

Re: Division on Maternal and Child Welfare

Your Reference Committee also reviewed report 1-D from the Division on Maternal and Child Welfare, and commends the Division for its statement on nurse responsibility in obstetrics and gynecology which will serve as guidelines for medical staffs of hospitals in determining local rules in relationship to obstetrical care by nurses and physicians.

Your Reference Committee also supports the position of the Division in testing for phenylketonuria, and its position that when a physician is required to report suspected cases of abused children the physician should be entirely free from threat of legal action. I move acceptance of the report of the Division on Maternal and Child Welfare.

(Motion seconded and carried.)

Re: Division on Chest Diseases

Report 1-E from the Division on Chest Diseases was studied by the Reference Committee, and its members concur with the Division in its recommendation that resolution 25, presented at the May 1964 session of the House of Delegates, be tabled. I so move.

(Motion seconded and carried.)

Re: Division on Handicapped Children

Report 1-F from the Division on Handicapped Children was reviewed, and your Reference Committee recommends its acceptance. I so move.

(Motion seconded and carried.)

Re: Division on Safe Transportation

Your Reference Committee also heard testimony from members of the Division on Safe Transportation and reviewed its work in the area of the physician's role in traffic safety and medical limitations on driver licensing. I move acceptance of report 1-G of the Division on Safe Transportation.

(Motion seconded and carried.)

Re: Division on School Health

The Reference Committee considered report 1-H from the Division on School Health and recommends its acceptance. I so move.

(Motion seconded and carried.)

Re: Commission on State Departments

Your Reference Committee concurs with the Commission on State Departments in its request that all Society committees ask for a spokesman from a particular division when it is considering legislation or other matters that have been reviewed by a division in detail. I move acceptance of the report of the Commission on State Departments.

(Motion seconded and carried.)

Re: Commission on Public Policy

The Reference Committee on Reports of Standing Committees also studied reports 5 and 5-A from the Commission on Public Policy. A listing of all legislation being considered by the Society is attached to report 5-A., but your Reference Committee would like to call attention to Bill 277-A which would permit chiropractors to use the title "Doctor." This legislation is now pending in the Senate, and your Reference Committee strongly urges that each delegate make it a personal responsibility to contact his State senator and explain the public health issues involved.

Your Reference Committee also recommends that the House of Delegates maintain the position that was adopted in May of 1963 concerning "implied consent." That position is to support the principle involved in "implied consent," but refers specific legislative proposals to the Commission on Public Policy.

Because the Commission is charged by the House with the duty of implementing the total legislative program of the Society, it must be able to analyze specific proposals and to adopt a position which will be consistent with the overall program being considered at any specific time.

I move acceptance of this portion of the report.

(Motion seconded and carried.)

Your Reference Committee would also like to point out to the House of Delegates legislation which would provide that non-profit sickness organizations and their agents, plans and contracts shall be subject to domestic insurance corporation laws which apply to domestic insurance companies formed to transact only disability, sickness and accident insurance.

The Society has opposed legislation similar to this in past sessions, and it is recommended that the House of Delegates reaffirm this position.

I move approval of this recommendation and acceptance of the reports of the Commission on Public Policy.

(Motion seconded and carried.)

Doctor Russell: I now move adoption of this report as a whole.

(Motion seconded and carried.)

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Dr. G. E. Collentine, Jr. (Milwaukee): In open hearing this morning, and in executive session this afternoon, your Reference Committee on Resolutions reviewed the resolutions and reports referred to it.

Re: Resolution 1

As to Resolution 1, your Reference Committee agrees with the Richland County Medical Society that a shortage of general practitioners exists in the State of Wisconsin and in the nation, and that a prominent cause of this shortage is a lack of proper emphasis on clinical medicine, including general practice, in medical education. However, it seems that establishment of chairs of general practice would not solve this problem, and that since the matter of improving general practice residencies and rotating internships is being studied by national organizations such as the American Medical Association, the American Academy of General Practice and the Association of American Medical Colleges, the resolution should be rejected at this time. I so move.

(Motion seconded and carried.)

Re: Resolution 2

Your Reference Committee next reviewed Resolution 2, introduced by the Manitowoc County Medical Society, relating to staff appointments. Your Reference Committee recognizes that the recommendations in this resolution are in accordance with the requirements of the Joint Commission on Accreditation of Hospitals, and we recommend acceptance of Resolution 2. I so move.

(Motion seconded and carried.)

Re: Resolution 3

Your Reference Committee recommends the adoption of the following substitute version of Resolution 3 as presented by the Sheboygan County Medical Society:

"WHEREAS, our aging population is increasing and many indigent older people will require financial help with their medical problems, and

"WHEREAS, the recommendations of the medical profession have been ignored, and an expanded and complex medical care bill for the aged is about to be passed by the Congress, and

"WHEREAS, it is the obligation of the medical profession to continue to provide the best possible medical care within the framework of any program; therefore, be it

"*Resolved:* That the physicians of Wisconsin declare their conviction that they should be free to provide medical care according to their best scientific and moral judgment, that the intimacy and privacy of doctor-patient relationship should be preserved, and that free choice of physician should be continued; and be it further

"*Resolved:* That doctors should be represented fully on all boards and committees empowered to direct and supervise the general administration of medical care for the aged, the amount of and distribution of fees, and the selection and approval of hospitals and nursing homes; and be it finally

"*Resolved:* That the Council of the State Medical Society of Wisconsin be urged to study the role of the Society in the implementation of the above." I so move.

Dr. D. J. Carlson (Milwaukee): I would suggest that in the second Resolved it read, "That doctors of medicine" be added. It would read, "*Resolved:* That doctors of medicine should be represented fully," and so on.

Speaker Callan: With the consent of the House we will accept the wording, "That doctors of medicine be fully represented."

(Motion seconded and carried.)

Re: Resolution 5

Resolution 5, introduced by the Douglas County Medical Society through the Council, had to do with the Interim Meeting. The Reference Committee notes that certain business of the Council and committees and of the House has been timed for action in the fall of 1965, and that further consideration of the implications of pending legislation may require action by the House of Delegates this fall.

Your Reference Committee therefore recommends rejection of Resolution 5 at this time. I so move.

(Motion seconded.)

Voice: What is Resolution 5?

Doctor Collentine: In essence the resolution calls for the fall or interim meeting to be held in abeyance in 1965. Let me read it: "That the interim meeting of the State Medical Society of Wisconsin be held in abeyance and such meeting be called only at the request of the President, the Speaker or the Council as may be necessary for the good of the State Medical Society of Wisconsin."

That is the resolution. The Reference Committee recommends rejection for 1965.

(Motion carried.)

Re: Resolution 14

Resolution 14 was introduced in October 1964 and laid over for action at this time. It recommended that Chapter XI, Section 3, paragraph 2 of the Bylaws be amended to read as follows:

"A member of a component society whose license has been revoked, suspended or voluntarily surrendered shall be dropped from membership automatically as of the date of revocation, suspension or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council."

Your Reference Committee agrees that this recommendation be accepted. I so move.

(Motion seconded and carried.)

Re: Constitutional Amendments

Your Reference Committee recommends that Article VIII, Section 3 of the Constitution of the State Medical Society of Wisconsin be amended by striking out the present Section 3 and substituting the following:

"SECTION 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10 per cent or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set the time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called." I so move.

(Motion seconded and carried.)

Your Reference Committee recommends that Article IX, Section 2 be amended by inserting the following sentence between the third and fourth sentences thereof:

"No individual shall be permitted to serve more than three successive three-year terms as Councilor wherever possible, and no more than a total of six terms of service as Councilor shall be permitted." I so move.

(Motion seconded.)

Dr. E. L. Bernhart (Milwaukee): I arise to ask just who decides the "wherever possible." That sounds rather ambiguous to me.

President-Elect Houghton: There was quite a hassle about this particular amendment in the Survey Committee. The reason for the words "wherever possible" was that in some of the northern districts, at least, it is difficult to get a man to serve as Councilor. This was put in to take care of that situation. You have a Councilor whose term of service is up, and if there is a certain number of years which he can serve, they will have to find another man as Councilor, and perhaps they can't. This was the only reason for the recommendation.

Doctor Bernhart: I would suggest that we reject this motion. We can't have an all-or-none rule concerning the term of office of Councilors. We should incorporate the matter in our regulatory mechanisms.

Speaker Callan: The motion is to adopt the proposed amendment to the Constitution and Bylaws.

(Motion carried.)

Speaker Callan: Since this vote entails a two-thirds vote, we will have to be a little more diligent in deciding the vote. All those in favor, please stand. Be seated. All those opposed, please stand.

SUPPLEMENTAL REPORT OF CREDENTIALS COMMITTEE

Doctor Hamlin: In addition to those delegates already registered and reported by the Committee on Credentials, 15 delegates and one alternate delegate have registered and are entitled to vote.

I move that this supplemental roll of delegates, alternate delegates and specially appointed delegates, totaling 94, representing 44 counties and 10 Sections, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

Speaker Callan: The constitutional amendment is adopted by greater than a two-thirds vote.

Re: Commission on Medical Care Plans

Doctor Collentine: Your Reference Committee next reviewed Report 2, of the Commission on Medical Care Plans. During consideration of the report in open session this morning, the chairman, Doctor Dessloch, informed your Reference Committee that the Commission has completed negotiation of a contract with the Office of Dependent Medical Care which retains the principle of "customary, reasonable and usual" fees.

Your Reference Committee recommends acceptance of the report with the addition of this supplementary material, and I so move.

(Motion seconded and carried.)

Re: Ad Hoc Committee on Redistricting

Finally, your Reference Committee reviewed Report 8, of the Ad Hoc Committee on Redistricting, and one of its representatives reported that a second meeting of the ad hoc committee had already been held since submission of the report; further, that a third and open meeting is scheduled to follow adjournment of the House of Delegates tomorrow morning. Your Reference Committee recommends acceptance of the preliminary report at this time. I so move.

(Motion seconded and carried.)

Doctor Collentine: I now move adoption of the report of the Reference Committee as a whole, as amended.

(Motion seconded and carried.)

■ REMARKS OF CHAIRMAN OF THE COUNCIL

Dr. James C. Fox (La Crosse): Tonight I have asked for the privilege of addressing you for a few moments regarding a problem that is very important to all of us in the practice of medicine. I think one of the main things that we as doctors have always fought for is the fact that when a gentleman receives his degree as a Doctor of Medicine he is a doctor of medicine; and it doesn't matter particularly what happens from then on—whether he becomes a pathologist, whether he becomes a general practitioner, whether he becomes a surgeon or whether he becomes one of the infantry-men in the practice of medicine, an internist—he is a doctor of medicine, and as such is entitled to all the privileges that go with his title as a doctor.

We as a corporate body are very much interested in any one segment of the practice of medicine, just as we are in any other segment. As a consequence, I thought it was of extreme importance that I read to you a telegram that we received today.

I am sure all of you are aware of the fact that the so-called Medicare bill, with certain refurbishings, passed the House of Representatives and is now in the Finance Committee of the Senate in Washington, D.C. There are pressures being brought to bear upon the senators regarding this bill, and we as doctors of course want to try to impress upon the senators our viewpoints regarding the bill. Unfortunately we were not allowed to do so before the House Ways and Means Committee, but we are going to be able to do some lobbying before the Senate Finance Committee. Whether it will be worth while or not we don't know, but at least we can try.

Today we received a telegram from our Executive Vice President to the following effect: The American Hospital Association has a campaign to place the services of pathologists, anesthesiologists, radiologists and physiatrists under the hospital services in Section 1 of H.R. 6675. They have barraged the senators in Washington with extremely heavy correspondence to this effect. This information comes from some hospital administrators, members of hospital boards of trustees and hospital-related groups.

As a consequence, we urge an all-out campaign from each and every one of you to step up communications to your U.S. senators to keep these four specialty categories of physicians out of the bill. I am sure you can understand why. These are not hospital services—they are medical services. Many hospital administrators and members of hospital boards of trustees do not favor inclusion of physicians' services. They are on our side.

Solicit their assistance in impressing on the members of the Senate that the practice of anesthesiology, or radiology, or physical medicine, or pathology is an integral part of the practice of medicine, in the same category as the practice of surgery, the practice of internal medicine, general practice, or any other designated field of medicine.

Gentlemen, I would ask very sincerely that all of you go to bat in this particular regard. Perhaps you can do it through your hospital administrators or your hospital boards of trustees. You yourselves can do it. You can do it through your influential friends. It is most important that the Senate, which after all, with all its wisdom, is not aware of the differences in the practice of medicine as distinguished from the hospital practice of medicine, should be enlightened, and you should explain why we want these particular services stricken from the first part of this bill.

(Meeting adjourned at 8:40 p.m.)

WEDNESDAY MORNING SESSION

May 5, 1965

The House of Delegates reconvened at 9:15 a.m., Dr. R. E. Callan, speaker, and Dr. G. A. Behnke, vice-speaker, presiding.

REPORT OF CREDENTIALS COMMITTEE

Doctor Hamlin: The third session of the House of Delegates, May 5, 1965.

The Committee on Credentials has verified the registration of 53 delegates and 13 alternate delegates entitled to vote at this session of the House.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 66, consisting of 42 county medical societies and 5 Sections, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

■ REPORT OF COMMITTEE ON NOMINATIONS May 1965

Dr. C. J. Picard (Superior): Your Committee on Nominations is pleased and honored to present the following slate of officers who have proven themselves through their ability, leadership and devotion to the State Medical Society.

For President-Elect: Dr. Frank E. Drew, Milwaukee.

For the office of Speaker: Dr. R. E. Callan, Milwaukee.

For the office of Vice-Speaker: Dr. George A. Behnke, Kaukauna.

For the office of Delegate to the American Medical Association to succeed Dr. A. A. Quisling, 1966–1967: Dr. William B. Hildebrand, Menasha.

To succeed Dr. R. E. Galasinski, 1966–1967: Dr. R. E. Galasinski, Milwaukee.

For the office of Alternate Delegate to the American Medical Association to succeed Dr. W. B. Hildebrand, 1966–1967: Dr. N. A. Hill, Madison.

To succeed Dr. George Collentine, 1966–1967: Dr. George Collentine, Jr., Milwaukee.

ELECTION OF OFFICERS

Speaker Callan: The first nomination made by the Committee is that of Dr. Frank E. Drew, for the office of President-Elect. Other nominations are in order at this time. What is your pleasure? Are there any other nominations? Hearing none, the Chair will ask for a motion that nominations be closed and that the Secretary be instructed to cast the unanimous ballot of the House for Dr. Frank E. Drew as President-Elect.

Doctor Sorenson: I so move.

(Motion seconded and carried.)

Vice-Speaker Behnke: The next nomination is that of Dr. R. E. Callan for the office of Speaker of the House for a two-year term. Are there any other nominations? If not, a motion is in order to close nominations and have the Secretary cast the unanimous ballot for Doctor Callan.

Dr. L. O. Simenstad (Osceola): I so move.

(Motion seconded and carried)

Speaker Callan: The next nomination is that of Dr. G. A. Behnke as Vice-Speaker. Are there any other nominations? If not, a motion is in order to close nominations and to instruct the Secretary to cast the unanimous ballot for Doctor Behnke.

Dr. E. W. Humke (Chilton): I so move.

(Motion seconded and carried.)

ELECTION OF DELEGATES

Speaker Callan: The next nomination is that of Dr. W. B. Hildebrand to succeed Doctor Quisling as Delegate to the AMA for a two-year term. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot for Doctor Hildebrand.

Doctor Sorenson: I so move.

(Motion seconded and carried.)

The next nomination is that of Dr. R. E. Galasinski to succeed himself as Delegate to the AMA for a two-year term. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot.

Dr. V. J. Bureh (Racine): I so move.

(Motion seconded and carried.)

The next nomination is that of Dr. N. A. Hill to succeed Doctor Hildebrand as Alternate Delegate to the AMA for a two-year term. Are there any other nominations? Hearing none, the usual motion is in order.

Doctor Simenstad: I so move.

(Motion seconded and carried.)

Speaker Callan: Next is Dr. George Collentine, Jr. to succeed himself as AMA Alternate Delegate for a term of two years. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot.

Doctor Humke: I so move.

(Motion seconded and carried.)

ELECTION OF COUNCILORS

(The House of Delegates nominated and elected the following Councilors for the respective Districts:)

Third District _____M. D. Davis, Milton
Sixth District _____George Nadeau, Green Bay
Seventh District _____James C. Fox, La Crosse.
Eighth District _____J. W. Boren, Jr., Marinette
Ninth District _____E. P. Ludwig, Wausau
Tenth District _____W. R. Manz, Eau Claire
Twelfth District ____S. L. Chojnacki, Milwaukee
Twelfth District ___S. W. Hollenbeck, Milwaukee
Thirteenth District Marvin Wright, Rhinelander

Speaker Callan: At this time the Chair wishes to recognize for the Society the long years of service and the very fine, loyal service that Dr. John Bell, Dr. Robert Mason, and Dr. R. C. Frank have given to the Society. I am sure we are going to miss them greatly. I think at this time we should stand and give them a big hand.

(Members arose and applauded.)

(Doctor Picard, chairman of the nominating committee, retiring President Doctor Curran, and incoming President Doctor Houghton escorted President-Elect Doctor Drew to the podium. The audience arose and applauded.)

REMARKS OF NEW PRESIDENT-ELECT

Doctor Drew: Thank you, gentlemen, for that ovation.

It is with humility and deep appreciation that I thank you for the high honor you have bestowed upon me this morning. I hope that my efforts and work will justify the confidence you have placed in me by electing me to this high office.

I am certain that we will achieve much by working together in unity and harmony, and I look forward to my new job with great zeal.

SUPPLEMENTAL REPORT OF CREDENTIALS COMMITTEE

Doctor Hamlin: In addition to those delegates already registered and reported by the Committee on Credentials, ten delegates and three alternate delegates have registered and are entitled to vote. Also, the Credentials Committee has been informed that Dr. L. J. Pfeiffer will act as delegate for Wood.

I move that this attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 79, comprising 48 county medical societies and 9 Sections, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

REMARKS OF THE SECRETARY

Secretary Crownhart: Back of me on my right is the motto of the State Society, adopted just after the Civil War. It is the only action of the House of Delegates, to my knowledge, that has never been changed in that length of time. I hope you recognize its translation. I assure you this comes from an academic background which is mine.

"Medicina Nusquam Non Est," freely translated, means, "The Art of Medicine is Universal." That will be your privilege to remember in the days ahead—that that which is universal cannot be destroyed by edict, fiat or bureaucracy.

As might be customary, but with even more feeling at this time, I join in thanks to Doctors Bell, Mason, Frank and Quisling, all of whom have long advised the Secretary, and effectively so.

Speaker Callan: A motion to adjourn is in order.

Doctor Sorenson: I so move.

(Motion seconded and carried.)

(House adjourned *sine die* at 9:45 a.m.)

■ ATTENDANCE AT HOUSE OF DELEGATES

	Sessions 1	2	3
SOCIETY:			
Ashland—Bayfield—Iron			
C. A. Grand, Ashland	x	x	x
J. M. Jauquet, Ashland	o	o	o

First name is delegate, indented name is alternate, x—present, o—absent.

	Sessions 1	2	3
Barron—Washburn—Sawyer—Burnett			
C. J. Strang, Barron	x	x	o
Robert Anderson, Cumberland	o	o	o
Brown			
R. P. Waldkirch, De Pere	x	x	x
Donel Sullivan, Green Bay	x	x	x
F. D. Cook, Green Bay	x	x	x
M. D. Blackburn, Jr., Green Bay	o	o	o
J. E. Dettmann, Green Bay	x	x	x
J. B. Grace, Green Bay	o	o	o
Calumet			
E. W. Humke, Chilton	o	o	x
J. C. Pinney, Hilbert	o	o	o
Chippewa			
M. W. Asplund, Bloomer	x	x	x
J. J. Sazama, Chippewa Falls	o	o	o
Clark			
M. V. Overman, Neillsville	x	x	x
E. D. Pfefferkorn, Colby	o	o	o
Columbia—Marquette—Adams			
R. T. Cooney, Portage	x	x	x
R. R. Rueckert, Portage	x	o	x
Crawford			
M. S. Garrity, Prairie du Chien	x	x	x
T. F. Farrell, Prairie du Chien	o	o	o
Dane			
R. N. Allin, Madison	x	x	o
W. P. Crowley, Madison	o	o	o
Robert L. Beilman, Madison	x	x	x
T. F. Heighway, Middleton	o	o	o
P. R. Kundert, Madison	o	o	o
J. H. Morledge, Madison	o	o	o
T. J. Nereim, Madison	x	x	x
K. L. Siebecker, Madison	x	x	x
W. T. Russell, Sun Prairie	x	x	x
A. V. Kanner, Madison	o	o	o
A. P. Schoenenberger, Madison	o	o	o
G. E. Oosterhous, Madison	x	x	x
R. A. Straughn, Madison	x	x	x
G. J. Derus, Madison	x	o	x
H. M. Suckle, Madison	x	x	x
P. G. Piper, Madison	o	o	o
Dodge			
L. W. Schrank, Waupun	x	x	x
William G. Richards, Beaver Dam	x		
Theodore Rowan, Beaver Dam		x	
Fred A. Karsten, Horicon			x
Door—Kewaunee			
W. G. Sheets, Sturgeon Bay	x	x	x
Patricia Lanier, Kewaunee	o	o	o
Douglas			
C. J. Picard, Superior	x	x	x
R. P. Fruehauf, Superior	o	o	o
Eau Claire—Dunn—Pepin			
D. R. Griffith, Eau Claire	x	x	x
G. G. Giffen, Eau Claire	o	o	o
A. A. Drescher, Menomonie	o	o	o
W. R. Manz, Eau Claire	x	x	x
Fond du Lac			
D. J. Twohig, Jr., Fond du Lac	o	x	o
W. G. Kendell, Fond du Lac	x	o	x
W. E. Myers, Fond du Lac	x	x	o
James A. Sisk, Fond du Lac	o	o	o
Forest			
E. F. Castaldo, Laona	x	x	x
B. S. Rathert, Crandon	o	o	o
Grant			
C. L. Steidinger, Platteville	o	x	x
H. W. Carey, Lancaster	x	o	o
Green			
R. G. Zach, Monroe	x	x	x
W. J. Staab, Jr., Monroe	x	o	x
Green Lake—Waushara			
Russell C. Darby, Wautoma	x	x	x
David J. Sievers, Berlin	o	o	o

	Sessions 1	2	3
Iowa			
W. D. Hamlin, Mineral Point	x	x	x
S. B. Marshall, Hollandale	o	o	o
Jefferson			
R. R. Liebenow, Lake Mills	x	x	x
Juneau			
V. M. Griffin, Mauston	x	x	x
Jack Strong, Mauston	o	o	o
Kenosha			
Richard Powell, Kenosha	x	x	x
Walter Rattan, Kenosha	o	o	o
Louis Olsman, Kenosha	o	o	o
Morris Siegel, Kenosha	x	x	x
La Crosse			
G. B. Murphy, Jr., La Crosse	x	o	o
R. B. Rasmus, La Crosse	o	x	x
D. L. Morris, West Salem	x	x	o
Frederick H. Wolf, La Crosse	o	o	o
Lafayette			
D. F. Ruf, Darlington	x	x	x
Lyle L. Olson, Darlington	o	o	o
Langlade			
Dee W. Dailey, Elcho	o	o	o
T. C. Fox, Antigo	o	x	x
Lincoln			
R. J. Henderson, Tomahawk	x	x	x
J. F. Bigalow, Merrill	o	x	x
Manitowoc			
T. H. Rees, Manitowoc	o	o	o
W. F. Smejkal, Manitowoc	x	x	x
Marathon			
E. P. Ludwig, Wausau	x	x	x
A. H. Stahmer, Wausau	x	x	x
Marinette—Florence			
C. E. Koepp, Marinette	x	x	x
J. W. Boren, Jr., Marinette	x	o	x
Milwaukee			
V. L. Baker, Milwaukee	o	x	o
R. T. Sproule, Milwaukee	x	x	o
N. G. Bauch, Milwaukee	x	o	o
W. L. Coffey, Jr., Milwaukee	x	x	x
E. L. Bernhart, Milwaukee	x	x	o
L. E. Rothman, Milwaukee	o	o	o
D. J. Carlson, Milwaukee	x	x	x
R. B Pittelkow, Milwaukee	x	o	o
J. F. Cary, Milwaukee	o	o	o
R. A. Nimz, Milwaukee	o	o	o
G. E. Collentine, Jr., Milwaukee	x	x	x
John Bareta, Milwaukee	o	o	o
E. G. Collins, West Allis	x	x	o
F. J. Millen, Milwaukee	x	x	o
W. J. Conen, Milwaukee	o	x	o
E. J. Schmidt, Wauwatosa	x	o	x
F. E. Drew, Milwaukee	x	x	x
P. G. LaBissoniere, Milwaukee	x	x	o
G. W. Dean, Milwaukee	x	x	x
Marvin Glicklich, Milwaukee	x	o	x
Norbert Enzer, Milwaukee	x	o	x
R. H. Lillie, Milwaukee	o	o	o
G. W. Hilliard, Milwaukee	x	x	x
T. F. Jennings, Milwaukee	o	o	o
G. S. Kilkenny, Milwaukee	o	o	o
R. J. Snartemo, Milwaukee	o	x	o
H. M. Klopf, Milwaukee	x	x	o
W. E. Finlayson, Milwaukee	x	o	x
H. J. Lee, Milwaukee	o	o	o
W. H. Frackelton, Milwaukee	o	o	o
George Murphy, South Milwaukee	x	x	o
R. H. Frederick, West Allis	o	o	o
Roger Laubenheimer, Milwaukee	x	x	o
G. F. Flynn, Milwaukee	x	x	x
Anne Roethke, Milwaukee	x	x	x
R. R. Watson, Milwaukee	o	o	o
F. A. Ross, Milwaukee	x	x	o
T. J. Cox, Milwaukee	o	o	o
D. M. Ruch, Milwaukee	x	x	o
K. A. Liefert, Wauwatosa	o	o	o

	Sessions 1	2	3
A. J. Sanfelippo, Milwaukee	x	o	x
J. R. O'Connell, Milwaukee	o	o	o
K. E. Sauter, Milwaukee	x	x	x
W. C. Webb, Milwaukee	o	o	o
H. F. Twelmeyer, Wauwatosa	x	x	o
D. W. Calvy, Milwaukee	o	o	o
L. R. Weinshel, Milwaukee	x	x	x
J. K. Olinger, Milwaukee	o	o	o
E. D. Wilkinson, West Allis	x	x	x
Rex Ruppa, Milwaukee	o	o	o
S. E. Zawodny, Milwaukee	x	x	o
J. R. Evrard, Milwaukee	o	o	o
Monroe			
C. B. Koch, New Lisbon	o	o	o
R. G. Konicek, Tomah	o	o	o
Oconto			
G. R. Sandgren, Suring	o	o	o
J. R. Culver, Oconto Falls	o	o	o
Oneida—Vilas			
Marvin Wright, Rhinelander	x	x	x
Henry S. Ashe, Minocqua	o	o	o
Outagamie			
G. A. Behnke, Kaukauna	x	x	x
William R. Richards, Appleton	o	o	o
W. H. Hale, Appleton	o	o	o
J. G. Bergwall, Hortonville	x	x	x
Ozaukee			
J. F. Walsh, Port Washington	x	x	o
R. H. Dorr, Belgium	x	x	x
Pierce—St. Croix			
P. H. Gutzler, River Falls	x	x	o
C. A. Olson, Baldwin	x	x	x
Polk			
L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederic	o	o	o
Portage			
F. E. Gehin, Stevens Point	x	x	x
A. J. Sowka, Stevens Point	o	o	o
Price—Taylor			
W. W. Meyer, Medford	x	x	x
J. L. Murphy, Park Falls	o	o	o
Racine			
V. J. Burch, Racine	x	o	x
William J. Little, Jr., Racine	o	o	o
Warren H. Williamson, Racine	x	x	o
Marvin W. Nelson, Racine	o	o	o
William Henken, Racine	x	x	o
S. M. Cushman, Jr., Racine	o	o	o
Richland			
R. W. Edwards, Richland Center	x	x	x
D. R. Shampo, Richland Center	o	o	o
Rock			
M. F. Purdy, Janesville	x	x	x
C. M. Carney, Beloit	o	o	o
D. M. Clark, Beloit	o	o	o
J. R. Schroeder, Janesville	o	o	o
Rusk			
Joseph E. Murphy, Ladysmith	x	x	x
Ralph Bennett, Ladysmith	o	o	o
Sauk			
E. V. Stadel, Reedsburg	x	x	x
J. A. Tibbitts, Reedsburg	o	o	o
Shawano			
H. F. Laufenburg, Shawano	o	o	o
Patricia J. Stuff, Bonduel	o	x	x
Sheboygan			
J. W. McRoberts, Sheboygan	x	x	o
James S. Jensen, Cedar Grove	o	o	o
Joseph F. Kovacic, Sheboygan	x	x	o
Donald M. Rowe, Kohler	o	o	o
Trempealeau—Jackson—Buffalo			
E. P. Rohde, Galesville	x	x	x
W. E. Wright, Mondovi	x	x	x
Vernon			
Robert A. Starr, Viroqua	x	x	x
Thomas Boston, Hillsboro	o	o	o
Walworth			
E. D. Sorenson, Elkhorn	x	x	x
R. S. Galgano, Delavan	o	o	o
Washington			
E. C. Quackenbush, Hartford	x	x	x
W. A. Nielsen, West Bend	x	o	o
Waukesha			
James V. Bolger, Jr., Waukesha	o	o	o
C. Samuelson, Hartland	o	o	o
Thomas Dugan, Waukesha	x	x	x
Richard G. Frantz, Waukesha	x	x	o
Waupaca			
Jerry Salan, Waupaca	o	o	o
Joseph W. Weber, New London	o	o	o
Winnebago			
Vincent G. Springer, Neenah	o	o	o
S. J. Graiewski, Oshkosh	x	o	o
E. N. Wright, Oshkosh	o	o	o
H. J. Colgan, Neenah	x	x	x
Wood			
Russell F. Lewis, Marshfield	x	x	x
Nelson A. Moffat, Marshfield	o	o	o
E. C. Glenn, Port Edwards	x	x	o
John E. Thompson, Nekoosa	o	o	x

SECTION

	Sessions 1	2	3
Anesthesiology			
Harry Thimke, Eau Claire	x	x	x
David Noll, Madison	o	o	o
Dermatology			
Joel Taxman, Milwaukee	x	x	x
G. O. Stubenrauch, Milwaukee	o	o	o
General Practice			
R. R. Richards, Eau Claire	x	o	x
J. A. Kelble, Milwaukee	o	o	o
Internal Medicine			
George Gutmann, Janesville	o	o	o
John Wishart, Eau Claire	o	o	o
Neurology—Psychiatry			
R. E. O'Connor, Madison	o	o	o
Edward E. Houfek, Sheboygan	o	o	o
Obstetrics—Gynecology			
Donald O. Price, Madison	x	x	o
R. E. Whitsitt, Madison	o	o	o
Ophthalmology—Otolaryngology			
Frank Treskow, Milwaukee	x	x	x
John Doolittle, Madison	o	o	o
Orthopedics			
John Van Driest, Sheboygan	o	o	o
Marvin Olson, Schofield	o	o	o
Pathology			
J. L. Teresi, Milwaukee	x	x	x
L. W. Kleppe, Beloit	o	o	o
Pediatrics			
Richard L. Myers, Green Bay	x	o	x
J. R. Guy, Waukesha	o	o	o
Public Health			
C. K. Kincaid, Madison	x	x	o
G. M. Shinners, Green Bay	x	x	x
Radiology			
Howard Mauthe, Racine	x	o	x
L. E. Jones, Racine	o	x	o
Surgery			
J. A. Killins, Green Bay	o	o	o
A. G. Martin, Milwaukee	x	x	o
Urology			
F. M. Hilpert, Racine	x	o	x
A. J. Jacobsen, Racine	o	o	o

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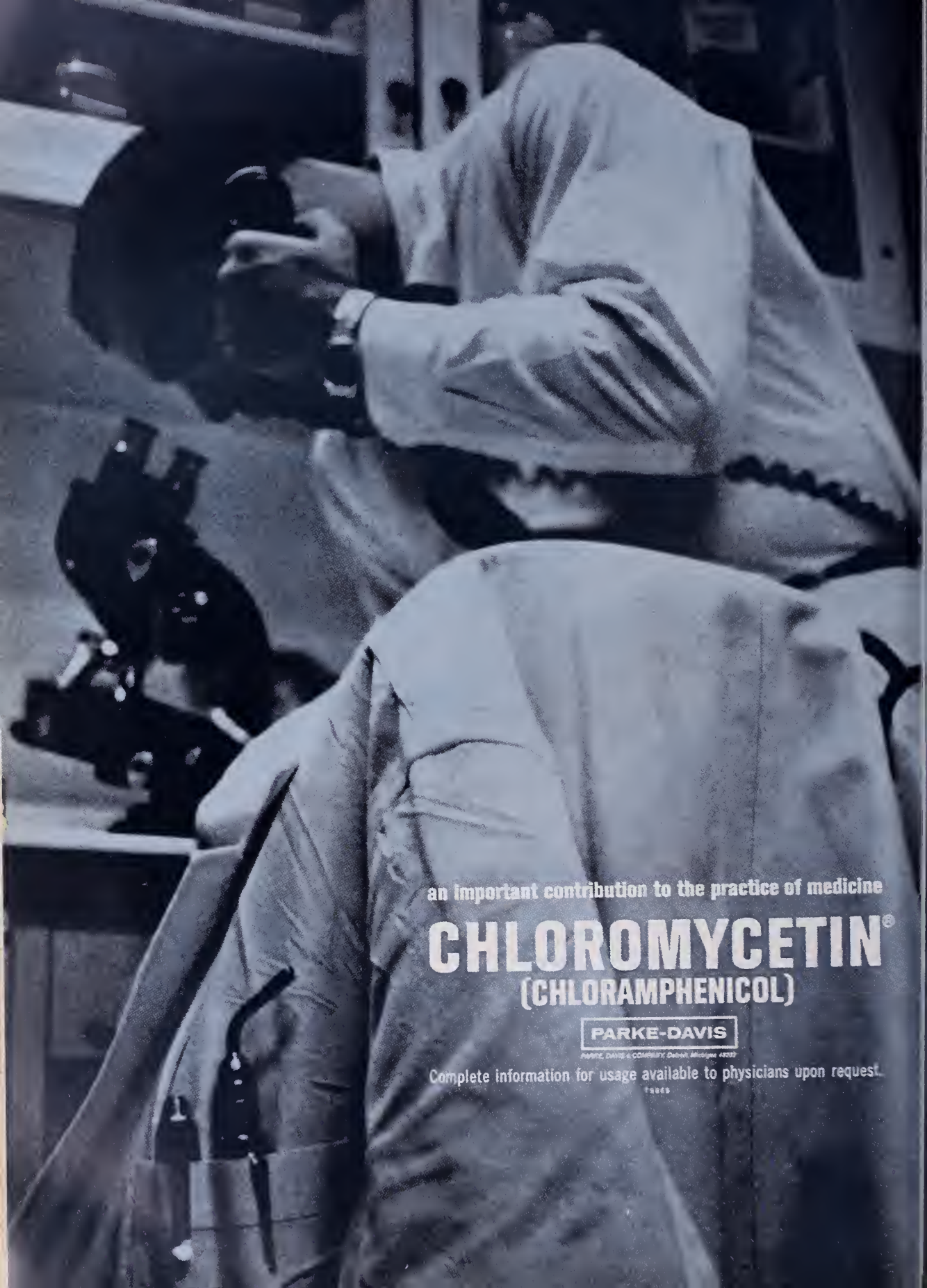
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COUNTY SOCIETY PROCEEDINGS

BROWN

The Brown County Medical Society met jointly with the Brown County Bar Association September 9 at the Northland Hotel, Green Bay. Following dinner, John Whitney discussed recent legislation in regard to the right to subpena physicians for a deposition and other current problems in interprofessional relationships.

DANE

New members of the Dane County Medical Society are *Drs. Mitchell A. Rapkin* and *Roy V. Yeazel.* A native of Milwaukee, Doctor Rapkin obtained his medical education at the University of Wisconsin, served his internship at Madison General Hospital, and completed a residency in anesthesiology at Wisconsin General Hospital. He is a fellow of the American College of Anesthesiologists. Doctor Rapkin is associated with Madison Physician Anesthetists. He is transferring from resident to a regular membership.

Doctor Yeazel was born at Marinette and received his medical degree in 1959 from Marquette University School of Medicine, Milwaukee. He interned at Milwaukee Hospital and is now associated with *Drs. William B. Hobbins* and *Samuel B. Harper* in Madison.

Election of officers will be held at the regular annual meeting of the Society October 12. The 1965 nominating committee, composed of *Drs. D. A. Peterson,* chairman, *O. O. Meyer, P. R. Kundert, W. T. Russell, J. F. Land,* and *W. V. Luetke,* reports the following slate of nominees: *Dr. C. K. Kincaid,* president-elect; *Dr. Gordon Davenport, vice-president;* *Dr. John Morledge,* secretary-treasurer; *Drs. W. T. Russell, H. M. Suckle, G. J. Derus,* and *G. E. Oosterhous,* delegates, and *Drs. E. I. Boldon, J. F. McIntosh, E. E. Johnson,* and *L. G. Crocker,* alternates.

The committee recommended the election of Doctor Morledge to fill the vacancy created by the resignation of Doctor Kundert as delegate for the term expiring in 1966, and election of *Dr. P. G. Piper* to fill the unexpired term of Doctor Morledge as alternate delegate.

DCMS golfers were undismayed by the bad weather, and an excellent turnout marked the annual golf tournament on September 21 at Blackhawk Country Club in Madison. *Dr. D. U. Cookson* won low gross with a score of 75 and *Dr. J. E. Miller* low net, with 88. *Dr. T. S. Kemp* was tournament chairman.

Approximately 75 gathered for dinner and some interesting movies on fishing and hunting in the Arctic, which were shown by *Dr. Carl Fosmark.*

KENOSHA

The Kenosha County Medical Society held a business meeting September 2 at the Elks Clubhouse in Kenosha.

Physicians whose names appear in italics are members of the State Medical Society.

MILWAUKEE

The Medical Society of Milwaukee County had two exhibits, "Your Glands" and "Careers in Medicine," at the Wisconsin State Fair in August.

"Your Glands" was a 20-foot exhibit designed to show through models and diagrams the location of the various glands and how they function. The career exhibit was prepared with the special aim of interesting high school and college students in becoming physicians. Emphasized were the wide range of opportunities in medical practice, teaching, research, and administration.

Ninety-four golfers participated in the Society's 38th Annual Golf Tournament July 20 at Ville du Parc Country Club, Milwaukee.

Dr. Durward Baker, Wauwatosa, won the President's Trophy for a first low gross with a score of 73. First low net for golfers with an established handicap at a home club went to *Dr. Saul Waxman,* West Allis, who tied *Dr. Stanley Hollenbeck,* Milwaukee, with a score of 63. Doctor Waxman won by a toss of a coin. *Dr. John Kearns,* Milwaukee, won the second low gross with a 76. After tying with *Dr. Michael Mehr,* Milwaukee, *Dr. Richard Clifford,* also of Milwaukee, won, by a toss-up, the first low net for golfers without an established handicap.

The St. Joseph's Hospital staff team won the James G. Garland Memorial Trophy with a team score of 407. Team members were Drs. Durward Baker and *William Baker,* Wauwatosa; *John Grade,* Elm Grove, and *George Meloy* and *Conde Conroy,* Milwaukee. The Mt. Sinai Hospital team took the URA Golfer Trophy with the second place score of 409. Team members were *Drs. Leonard Robbins, Barney Becker, Marvin Sattler, Robert W. Mann,* and *Alvin Kurzon,* all of Milwaukee.

RACINE

The Lincoln Lutheran Home in Racine was the setting for the September 23 dinner meeting of the Racine County Medical Society. A tour of the Lincoln Lutheran—Alcoholic Center was held, followed by a business meeting.

TREMPEALEAU–JACKSON–BUFFALO

New developments in Rh factors were discussed by Dr. Paul J. Meis as speaker for the meeting of the Trempealeau–Jackson–Buffalo County Medical Society September 28. Doctor Meis is the new obstetrician and gynecologist with the La Crosse Clinic.

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COUNTY SOCIETIES *continued*

Wives of members were invited to the dinner meeting, held at the Club Midway in Independence.

WINNEBAGO

Dr. Waldo Varberg, Neenah, was guest speaker for the dinner program of the Winnebago County Medical Society September 2 at Valley Inn, Neenah. His subject was "Fractures of the Forearm in Children."

* * *

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Wisconsin Diabetes Association Camp

The 16th annual camp program for diabetic children was sponsored by the Wisconsin Diabetes Association in August and early September. For two weeks beginning August 6, 16 girls were at Camp Sidney Cohen on Lake Nemahbin. August 23, 32 boys left for a fortnight at Camp Whitcomb on Lake Keesus. *Dr. Thomas A. Prier*, Milwaukee, Diabetes association president, said the number of children at camp was the largest in at least five years.

Doctor Prier was one of 15 physicians from the Milwaukee area who made voluntary daily camp visits on an alternating basis. Others participating included *Drs. Karl H. Beck, Mark J. Ciccantelli, Addis C. Costello, Julius M. Meyer, Bruno J. Peters, Donald A. Roth, John D. Stuhler, Walter H. Thiede, William L. Treacy*, and *Ronald K. Wells*.

Northern Branch, WPA

The Northern Branch of the Wisconsin Psychiatric Association was host to the entire WPA membership September 18 at Winnebago State Hospital. The annual event was cosponsored by the hospital staff.

Headlining the program was Dr. Carl A. Whitaker, Madison, a new addition to the staff of the Department of Psychiatry at the University of Wisconsin, whose subject was "Family Therapy." Doctor Whitaker came to Wisconsin from Atlanta, Ga., where he headed the Department of Psychiatry at Emory University.

Dr. Darold A. Treffert, superintendent at Winnebago, welcomed the assemblage and served with *Dr. C. F. Midelfort*, La Crosse, as a discussion leader. Following an interview of a patient and family conducted by Doctor Whitaker, there were questions from the audience, and then the WPA business meeting.

The program was preceded by a tour of the new Gordon Hall of the Child–Adolescent Unit at the hospital. After dinner, there was a slide presentation by *Dr. James C. Payne*, Oshkosh, on a hunting safari in the Far East and Africa. *Dr. Stanley Miezio, Jr.*, of the Winnebago staff, was program chairman.

Milwaukee County Medical Assistants

Open to all medical assistants in Milwaukee County was the September 16 meeting of the Milwaukee County Medical Assistants Society. The meeting, first of the 1965–1966 season, was conducted by Miss Judy Kerl, president, at the clubhouse of the Federation of Women's Clubs on Prospect Avenue, Milwaukee. Speaker was Sister Mary Estelle, director of student personnel at Mount Mary College, whose topic was "Understanding Each Other."

The Society's October meeting on the 21st will be a dinner meeting at Vitorio's featuring *Dr. Robert A. Nimz* of Milwaukee in a discussion of alcoholism.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

ACP Midwest Regional Meeting

The Midwest regional meeting of the American College of Physicians (for internal medicine specialists in Illinois, Indiana, Iowa, Minnesota, and Wisconsin) was held October 16 at the Wisconsin Union Theater in Madison.

Following introductory remarks by *Dr. J. LeRoy Sims*, ACP governor for Wisconsin and professor of medicine at the University of Wisconsin Medical School, a welcome was extended by *Dr. Peter L. Eichman*, dean of the UW Medical School. Wisconsin men on the program included *Drs. Richard H. Wasserburger* and Murray Epstein, Madison, "Electrocardiograms Simulating Myocardial Infarction, Review of the World Literature with Brief Presentation of Ten Illustrative Cases;" *Dr. G. L. River*, Marshfield, "Erythroid Aplasia Following Thymomectomy;" *Drs. A. V. Pisciotta* and *A. P. Ziebert*, Milwaukee, "The Effect of Plasma from Patients with Thyrotoxicosis on the Mitotic Index of Peripheral Blood;" Drs. Lawrence Sherman and *Arlan Rosenbloom*, Madison, " 'Idiopathic' Spontaneous Hypoglycemia of Infancy as an Expression of the Metabolic Defect in Diabetes Mellitus;" and Drs. John R. Petersen, *Norman H. Engbring*, James Cerletty, and Richard Holmes, Milwaukee, "Partial Anterior Pituitary Insufficiency." *Dr. F. N. Lohrenz*, Marshfield, was one of three men presenting a discussion of "Familial Decrease in Cortico–Steroid Binding Globulin (CBG)."

The meeting was under the direction of Doctor Sims. *Dr. John D. McMaster*, Madison, was chairman of the committee on local arrangements and *Dr. J. D. Kabler*, also of Madison, was chairman of the committee on scientific program.

ACS, Wisconsin Division

The 11th Annual Fall Cancer Conference was held September 25 at the University of Wisconsin Medical Center, Madison, with the American Cancer Society's Wisconsin Division cosponsoring the event with the clinical oncology division of the University Medical School.

A paper on some aspects of the cause of cancer was presented by Dr. Paul Kotin, associate director for field studies of the National Cancer Institute, and reports were heard on the clinical oncology division's work.

The conference followed a clinical cancer chemotherapy course held September 24 at the Medical Center. Doctor Kotin reviewed the cancer research program as featured speaker at a reception and din-

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ner in the evening. Program directors for the course were *Dr. A. R. Curreri*, director of the division of clinical oncology, and *Dr. F. J. Ansfield*, professor of clinical oncology.

WHA, TOPS Club

The Wisconsin Heart Association and the Hopeful Losers TOPS Club of West Bend sponsored a movie on obesity and heart disease in August in the auditorium of the new Washington County Courthouse at West Bend. *Dr. James F. Baumgartner* of the General Clinic staff in West Bend spoke on "Your Weight and Heart Disease." A question and answer period followed.

Dane County Health Councils

Progress in the prevention and treatment of heart disease and cancer was the theme for the 20th annual meeting of the Dane County Association of Health Councils, September 16 at the Dane County Fairgrounds in Madison. The program was organized through the cooperation of the Dane County Unit of the Wisconsin Heart Association and the American Cancer Society.

Speakers addressing the councils were *Dr. Richard H. Wasserburger*, associate clinical professor of medicine at the University of Wisconsin Medical School, on heart disease, and *Dr. John Scott*, assistant clinical professor of surgery, on cancer.

A highlight of the afternoon session was a panel discussion moderated by *Dr. Peter L. Eichman*, dean of the University of Wisconsin Medical School. Participants—all UW faculty members—included Doctors Wasserburger, Scott, *William B. Hobbins*, assistant clinical professor of surgery, and Robert Corliss, instructor in medicine.

The program was organized through the cooperation of the Dane County Unit of the Wisconsin Heart Association and the American Cancer Society.

Milwaukee Chapter, WPA

The following officers were announced at a dinner meeting of Milwaukee Chapter of the Wisconsin Psychiatric Association on June 2: *Dr. Jack E. Geist*, president; *Dr. Samuel B. Black*, president-elect; *Dr. Morris Gelfman*, secretary; *Dr. Donald Ratke*, treasurer; and Drs. William J. Crowley, *Morton Josephson*, and *Jack J. Coheen*, councilors.

The after-dinner speaker was Dr. Lewis Robbins, medical director of Hillside Hospital, Glen Oaks, N.Y., whose topic was psychiatric hospitalization. Forty-five psychiatrists were present at the dinner meeting, and several came in just for the presentation.

Kenosha County Unit, ACS

Dr. Harry Schwartz has been named president of Kenosha County Unit of the American Cancer Society. Reelected to office at the summertime meeting was *Dr. Louis Olsman*, first vice-president, who was

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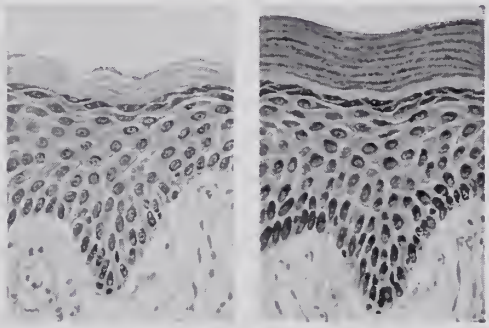

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References: (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Investig. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Fellman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

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also one of the delegates chosen to attend the state convention slated for October in Madison. *Dr. Paul Capelli* was one of seven men and women elected to three-year terms as members of the board.

Wisconsin Heart Association

Three physicians were among the eight speakers at a Cardiac-in-Industry conference held August 11 at Port Edwards.

Dr. George A. Hellmuth, director of comprehensive and family medicine at Marquette University School of Medicine, Milwaukee, told the gathering that a big problem in heart attacks is fear—fear by the person suffering an attack as to how he can provide for his family and fear and reluctance by industry to employ cardiacs. *Dr. Donald Rowe* of the Kohler Company medical department said his company has had a voluntary program for employes in which x-rays and electrocardiograms are recommended for those over 35 in an attempt to detect heart diseases and take preventive measures. *Dr. Robert L. Johnson*, Wisconsin Rapids, conference chairman, was the third physician on the program.

Others who spoke were James R. Leffler, compensation claims manager for Employers Mutuals of Wausau, who reported that a recent study shows that the relationship between physical strain and heart attacks appears to be coincidental; Clare Rejahl, Madison, rehabilitation consultant for the State Division of Vocational Rehabilitation; Norman J. Taugher, Madison, deputy director of the Wisconsin Workmen's Compensation Division; Albert C. Goldberg, Milwaukee, an attorney handling compensation claims for the AFL–CIO, and Miss Catherine Chambers, R.N., Madison, nursing consultant for the Wisconsin State Board of Health.

One of several Wisconsin Heart Association gatherings held around the state this year, the conference was jointly sponsored by Wood–Portage County Unit of the association, the Wood County Medical Society, and the Wisconsin Rapids area Chamber of Commerce.

Board of Nursing Elects

The Wisconsin State Board of Nursing, at its annual meeting July 14, elected Miss Frances Avery, R.N., associate professor, Marquette University College of Nursing, Milwaukee, as its president and Miss Anne Geyer, R.N., director of nursing, Methodist Hospital, Madison, as vice-president.

Appointed to a four-year term on the Committee of Examiners for Nurses (R.N.) was Miss Corinne Drexler, R.N., instructor at Marquette University College of Nursing. Sister M. Jordan, R.N., director, Sacred Heart School of Practical Nursing, West Allis, was reappointed to a three-year term on the Committee of Examiners for Trained Practical Nurses. Mrs. Charlene Flick, T.P.N., Madison, a graduate of the Madison Vocational, Technical and Adult School Program in Practical Nursing, began a three-year term on the same committee.

Present membership of these committees is: Committee of Examiners, R.N.—Bonnie J. Field, R. N., chairman, Milwaukee; Sister M. Constance, R.N., Milwaukee; Corinne Drexler, R.N., Milwaukee; Sister M. Carmel, R.N., Manitowoc, and Adele G. Stahl, R.N., secretary, Madison; Committee of Examiners, T.P.N.—Sister M. Jordan, chairman, Milwaukee; Mrs. Florence Byrne, T.P.N., Superior; Mrs. Eleanora Dobberfuhl, T.P.N., Greenleaf; Mrs. Margaret Dykeman, R.N., Kenosha; Mrs. Charlene Flick, T.P.N., Madison, and Adele G. Stahl, R.N., secretary, Madison.

Wisconsin–Upper Michigan Society

Dr. George H. Anderson, Stevens Point, was elected president of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology at the group's fall meeting September 11–12 at Lake Delton. *Dr. George L. McCormick*, Waukesha, formerly of the Marshfield Clinic, was reelected secretary-treasurer.

Guest speakers at the meeting, which was held jointly with the Wisconsin Otolaryngologic Society, were Dr. G. O'Neil Proud, Kansas City, Kan., of the University of Kansas faculty, and Dr. Robert C. Watzke, Iowa City, of the University of Iowa.

The Society's next meeting will be held at the University of Wisconsin–Madison.

Dane County Unit, ACS

Dr. William B. Hobbins, Madison, was reelected president of the Dane County Unit of the American Cancer Society at a meeting held September 13. Among those elected to the board of directors was *Dr. Raymond E. Whitsitt*, Madison.

* * *

CLINICAL CENTER STUDY OF HODGKIN'S DISEASE AND LYMPHOSARCOMA

The cooperation of physicians is requested in a study of Hodgkin's disease and lymphosarcoma being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Particularly desired are patients who have had no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. The major purpose of the study is to determine the curative potential of intensive radiotherapy in localized cases and to evaluate combination chemotherapy and X-irradiation in patients with generalized involvement.

Physicians interested in having their patients considered for the study may phone or write to: PAUL P. CARBONE, M.D., The Clinical Center, National Institutes of Health, Building 10—Room 12N-228, Bethesda, Maryland 20014. Telephone: 656–4000, Ext. 64251, (Area code 301).

NEWS OF WISCONSIN PHYSICIANS

State MDs on AMA Radio Programs

Two Wisconsin physicians are among the men and women chosen for the 26 ten-minute interviews in a new radio series on health subjects produced by the American Medical Association. Though each program stands by itself, all have the same underlying theme—the listener's health. Physicians selected for the interviews were carefully selected to speak for the AMA.

The Wisconsin doctors appearing on the series are *Dr. Harry Foerster, Jr.*, Milwaukee, whose subject is "Cosmetics," and *Dr. Herman Heise*, Milwaukee, "Safe Driving." Other subjects discussed in the series are acne, arthritis, blood pressure, bones and joints, cancer, children's sex education, diabetes, emergency medical identification, emotional problems, environmental hazards, health and fitness, immunizations, indigestion, keeping posted, medicine and religion, menopause, nutrition, pesticides, rural health, sports and health, stroke, tuberculosis, water and health, and volunteer health agencies.

Four Join Winnebago Staff

Appointment of four new psychiatrists and the promotion of a fifth were announced at Winnebago State Hospital late in August by Dr. Thomas J. Kelley, clinical director.

Dr. Jerome Szymanski, who completed residency training at University Hospitals, Madison, has been promoted to the post of assistant clinical director in charge of special treatment programs including an alcoholic unit which opened October 1, and a psychiatric geriatric service. New staff members are Dr. George Lysloff, former clinical director at the State Mental Hospital, Yankton, S.D., who has been named chief of one of the hospital's two female psychiatric services; Dr. Eleanor Struck, former medical director at Washington County Institutions, staff psychiatrist on female service; Dr. Richard Stafford, who completed psychiatric residency training at University Hospitals, Madison, psychiatrist in the child–adolescent unit; and Dr. Laszlo Litkey, from the New Jersey State Hospital at Trenton, psychiatrist responsible for forensic psychiatry.

The new alcoholic unit answers a need long recognized in the Winnebago Hospital area, Doctor Szymanski said. He estimated that about 22 per cent of Winnebago's 1,800 annual patient load are alcoholics. With creation of the unit, he said, admissions can be expected to increase.

Dr. Goldstein Reelected

Dr. D. N. Goldstein, Kenosha, editorial director of the WISCONSIN MEDICAL JOURNAL and member of the State Medical Society's Commission on Medical Care Plans, has been reelected delegate to National Blue Shield by the State Medical Society, *Dr. E. M. Dessloch*, Prairie du Chien, commission chairman, announced in August.

As delegate, Doctor Goldstein will represent the Society and its health insurance plan, Wisconsin Physicians Service, at national Blue Shield meetings, and he will also serve as observer at AMA meetings.

Doctor Goldstein was reelected to the Commission on Medical Care Plans in July, along with *Dr. Robert Krohn*, Black River Falls, vice-chairman; *Dr. John T. Sprague*, Madison, treasurer; *Dr. E. J. Nordby*, Madison, assistant treasurer; and *Dr. W. T. Casper*, Milwaukee, alternate delegate to National Blue Shield and alternate AMA meeting observer.

Mayo Residents Locate in State

Three residents in the Mayo Foundation, Rochester, Minn., have left that city to locate in Wisconsin. Dr. Charles J. Drexler, resident in radiology, has located in Eau Claire; Dr. Knud C. Stobbe, surgery, in Milwaukee, and Dr. Blake E. Waterhouse, internal medicine, at Madison.

Dr. Wagelie at Beloit

Dr. Reuben G. Wagelie began practice at Beloit in May in association with *Drs. D. M. Clark* and *G. C. Matthews*. A pediatrician and allergist, Doctor Wagelie received his M.D. degree in 1956 from the University of the Philippines and did postgraduate work in pediatrics and allergy at Michael Reese Hospital, Chicago, and Baylor University's School of Medicine, Houston, Tex.

Dr. Hatfield Resigns

Dr. Margaret E. Hatfield, Kenosha city health director since January 1960, has resigned from that post and is returning to Elkhorn, where she lived before moving to Kenosha.

Dr. Bates at Fort Atkinson

Since shortly after July 1, Dr. Donald E. Bates has been associated in general practice with *Drs. O. H. Hanson* and *J. J. Harris*, Fort Atkinson. He and his wife and four children planned to move to Fort Atkinson as soon as Doctor Bates completed his internship at the Tucson Medical Center, Tucson, Ariz. He received his medical degree in 1964 from the University Louisville, Louisville, Ky.

Dr. Pili Opens Clinton Office

Dr. D. B. Pili, Jr., opened an office for the practice of medicine and surgery September 1 at Clinton. A native of the Philippines, he is a 1955 graduate

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PHYSICIAN NEWS *continued*

of the University of Santo Tomas, Manila. Prior to locating in Clinton he was house physician and then senior resident in general surgery at St. Elizabeth Hospital, Chicago.

Dr. Goedecke Honored

Dr. and Mrs. *R. H. Goedecke* were honored guests August 16 when the West Salem Lions Club held its Ladies' Night Banquet at Maple Grove Country Club, West Salem. With their little son, the two are now making their home in Florida. Doctor Goedecke retired several months ago after practicing medicine in West Salem for 35 years.

Dr. Miller Joins Counseling Center

Dr. Milton H. Miller, Madison, professor and chairman of the Department of Psychiatry at the University of Wisconsin Medical School and director of the Wisconsin Psychiatric Institute, accepted the post of medical director of the Jefferson County Family Counseling Center at Jefferson during the summer. He is at the center one day a week. Another addition to the staff at the center is Henry Kaplan, Ph.D., Madison psychologist who is assistant director of the Child–Adolescent Treatment Unit at Mendota State Hospital. He is serving half time at the center.

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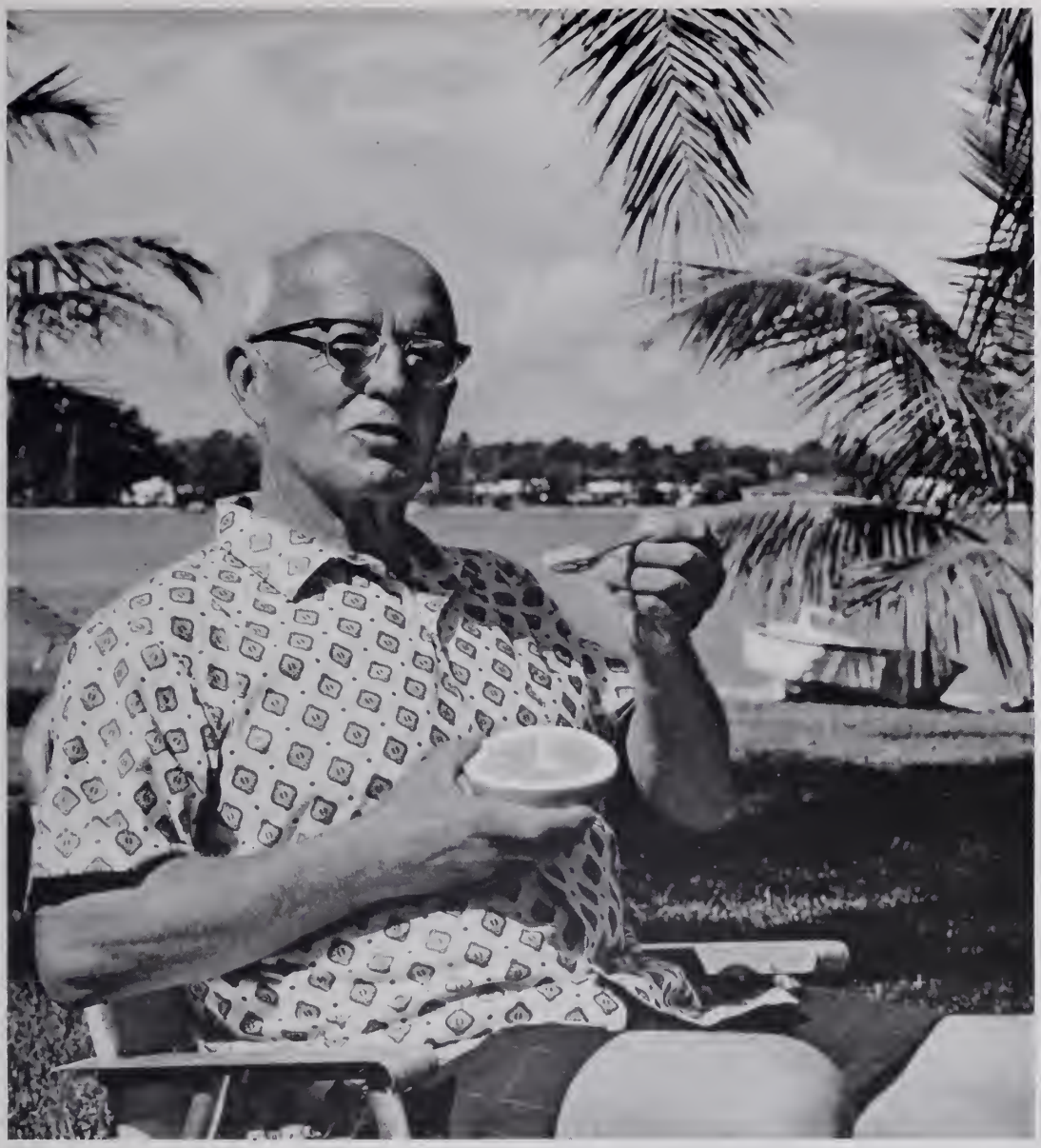

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Dr. Leahy Honored

August 22 was "Dr. Leahy Day" in Park Falls. On that date an estimated 350 persons thronged the Park Falls Country Club for a public reception honoring *Dr. J. D. Leahy*, who on May 15 completed 50 years of medical practice. Later in the day, the Price–Taylor County Medical Society gave a banquet for Doctor Leahy at the Northwoods Inn. Glenn Waldschmidt, Wausau, regional representative of the State Medical Society, on behalf of the Society presented Doctor Leahy a walnut council chair in remembrance of the 12 years during which he served on the Council. He has been speaker of the House of Delegates and has served on several SMS committees, and he is currently president of his county society, which he has also served as secretary.

Doctor Leahy was one of the founders, and first president of the board of directors, of Park Falls Community Hospital, where he has also been president of the staff. Among the other posts he has held is that of health officer of the City of Park Falls, and the Town of Lake.

One of the highlights of the celebration for Doctor Leahy and his wife was the fact that their entire family was home, including their physician son, Dr. James J. of Omaha, Neb.

Photo courtesy PARK FALLS HERALD

THE PRESENCE of their entire family was a highlight for Dr. and Mrs. J. D. Leahy at the "Dr. Leahy Day" celebration August 22 in Park Falls. Pictured with Doctor Leahy and his wife at the reception at Park Falls Country Club are their two sons: Dr. James J., Omaha, Neb. (left), and Robert Leahy, an attorney at St. Paul, Minn.

Dr. Schrock Featured

Dr. J. B. "Joe" Schrock was featured August 19 in a "Know Your Business Man" feature in the SHARON REPORTER. The article refers to him as "of the 'old school' which developed men . . . who will answer calls, day and night, and otherwise go that 'extra mile' for mankind."

Mentioned in the laudatory REPORTER story is the fact that Doctor Schrock came to Sharon in 1949. Organizations of which he is a member include the Walworth County Medical Society, which he has served as president. He is also a past president of the Lakeland medical staff, and is now serving as a member of the Lakeland executive committee.

Dr. Johnson Does Experimental Surgery

The ELKHORN INDEPENDENT of August 5 carried an illustrated feature on the Allen–Bradley Science Laboratory, located on the grounds of Milwaukee County General Hospital, and the studies and experimentation in open heart surgery going on there. A reporter from the Elkhorn paper described surgery on a dog performed by Dr. W. Dudley Johnson for the purpose of observing the effects of adenosine as it was added to the blood stream during the two hours the dog was on the heart machine.

Dr. Derward Lepley, Jr., heads the doctors involved in cardiovascular research at the laboratory, the Elkhorn reporter stated.

Dr. Burgemeister at Beaver Dam

Dr. George Burgemeister became associated during the summer with *Dr. E. R. Taake* and *Dr. W. H. Snook* in their medical clinic at Beaver Dam. A 1962 graduate of the University of Wisconsin Medical School, he located in Beaver Dam following two years spent with the U.S. Public Health Service at Portland, Ore.

Dr. Wood Opens Amherst Office

Dr. C. F. Wood, Iola physician, opened his new offices in Amherst early in September. He is in that community Monday, Tuesday, Wednesday, and Friday afternoons. Amherst had been without a doctor since January 1964, when *Dr. Steve Osicka* moved to Berlin.

Dr. Moore Moves Office

Dr. James N. Moore has moved his medical offices in Madison from Monroe Street to the Westgate Medical Arts Building.

UW Men Win Citation

Dr. J. M. B. Bloodworth, Jr., professor of pathology at the University of Wisconsin Medical School, Madison, and R. L. Engerman, Ph.D., assistant professor of surgery (ophthalmology) received the 1964 Fight for Sight Citation of the National Council to Combat Blindness, Inc. The two won the award for their co-authorship of the paper, "Experimental Diabetic Retinopathy in Dogs."

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Dr. Nickels at Hartford

Dr. Robert Nickels has moved to Hartford from Saginaw, Mich., to establish a private practice in surgery in association with *Dr. T. J. Kern*. Doctor Nickels, who received his M.D. degree at Indiana University, interned at Milwaukee County General Hospital and had two years of training at the Veterans Administration Hospital in Saginaw and three years of surgery at St. Joseph Hospital, Milwaukee.

Dr. Mathwig Featured

Dr. Robert J. Mathwig of Stanley is the subject of a "Personality of the Week" feature in the CHIPPEWA FALLS HERALD–TELEGRAM of September 4. Entitled "Master (doctor) of one trade, jack of a few more," the article recounts how Doctor Mathwig at an early age became an amateur taxidermist. The hobby tied in with his lifelong enthusiasm for hunting and fishing. In addition, the Stanley physician has taught himself the skills of carpentry. Since buying an old home in 1946, he has renovated at least part of every room and he has also done some landscaping around the outside.

Dr. Glunz at Beaver Dam

Drs. William G. Richards, Theodore Rowan and *E. Bruce Wohlwend* announce the association of Dr. Paul R. Glunz in the practice of pathology at the Clinical Pathology Laboratory at Beaver Dam. Doctor Glunz comes to Beaver Dam from the Armed Forces Institute of Pathology at Washington, D.C., where he was acting chief of the hepatic branch.

Dr. Mallery Reappointed

Dr. O. T. Mallery, Wausau, medical director of Employers Mutuals, has been reappointed to the Medical Advisory Council of the American Association of Industrial Nurses. He has served since 1955 on the council, which is composed of leading industrial physicians and serves as liaison between the industrial medical and the industrial nursing professions.

Dr. Meyer at Spring Valley

Dr. Robert J. Meyer opened practice at the Spring Valley Clinic in September. Originally from Minneapolis, he had a private practice in Bethany, Okla., before coming to Spring Valley.

Dr. Mescher Attends Seminar

Dr. Thomas Mescher of the Bump Medical Group in Rhinelander attended a one-week seminar on "Advances in Pediatrics" in August at the University of Colorado School of Medicine in Denver.

Dr. Sincock Reappointed

Dr. H. A. Sincock, Superior, is one of the five members of the Advisory Hospital unit reappointed by *Dr. E. H. Jorris*, state health officer, to terms ending July 1, 1968.

UW Assistant Dean Appointed

Dr. Thomas C. Meyer, a pediatric cardiologist, in mid-September was appointed assistant dean of the University of Wisconsin Medical School, Madison, according to an announcement by *Dr. Peter L. Eichman*, dean.

The 38-year-old physician, since 1961 an assistant professor of pediatrics at the medical school, will be responsible for postgraduate medical education. Dean Eichman said the post had been created "because of the tremendous growth of the medical school program of continuing education for physicians." Last year more than 1,600 physicians from the state and nation attended postgraduate courses sponsored by the medical school and the University Extension Division.

Thomas C. Meyer, M.D.

Doctor Meyer will continue the present postgraduate program, which includes each year a series of seminars lasting from two days to six weeks, and also plans for "some exciting new methods of reaching practicing physicians," Doctor Eichman said. "I am especially interested in experimenting with methods to develop the highest quality of postgraduate training within the practicing physicians' own localities," Doctor Meyer said.

He plans for example to initiate a series of telephone conferences between physicians in the state and medical school faculty members. The conference-call courses will begin in the fall.

In addition, a library of self-rewinding tapes will be made available to interested physicians for reference. The tapes would briefly record current comments of medical school faculty members regarding management of various problems.

Doctor Meyer pointed out that in the development of these methods, the medical school will work closely with state and local chapters of specialized medical groups, such as the Wisconsin Academy of Practice, and especially with the State Medical Society.

In addition to experimenting with new methods, Doctor Meyer will be responsible for a series of concentrated one-day courses which will cover latest developments in specialties such as psychiatry, surgery and neurology.

"The present postgraduate courses, to be continued, are highly-scientific, sophisticated types of courses encompassing the latest research developments. The courses have national appeal, drawing faculty from national and international fields," Doctor Meyer said.

The new assistant dean is a native of South Africa and received his medical degree from the University of Witwatersrand in Johannesburg. He

held residency appointments in South Africa and Birmingham, England.

His medical fellowships include one in cardiology in 1956 at Johns Hopkins University Hospitals in Baltimore, and in 1957–58 in neurology at the University Hospital in Saskatoon, Saskatchewan, and Queens Square Hospital, London, England.

Father Raynor New Marquette President

Father John P. Raynor, S.J., academic vice-president of Marquette University, Milwaukee, on September 9 became the university's 20th president. He succeeded Father William F. Kelley, S.J., president since Feb. 18, 1962, who left to undertake a broad study of the 28 American Jesuit colleges and universities, of which MU is the largest. He will serve as an expert consultant to Father Vincent T. O'Keefe, S.J., chairman of a special commission set up to study American Jesuit higher education. Father O'Keefe was president of Fordham University, New York, until he relinquished his duties this month to reside in Rome and carry out his new responsibilities.

Named Fellows in APA

Seven Madison and Milwaukee psychiatrists have been named fellows in the American Psychiatric Association. They are: *Drs. Herman P. Gladstone, Seymour L. Halleck, Henry A. Peters,* and *Leigh M. Roberts,* all of University Hospitals, Madison, and *Drs.* Max J. Primakow, *H. Gladys Spear,* and *William H. Studley,* Milwaukee.

Open Watertown Practice

Dr. Thomas A. Schroeder, who joined the staff of the Wilkinson Clinic in Oconomowoc September 1 as an obstetrician and gynecologist, has become associated with another Clinic obstetrician and gynecologist, *Dr. John Claude,* in a medical practice at Watertown. The two are holding office hours there Monday, Wednesday, and Thursday afternoons and Saturday mornings. Doctor Schroeder received his M.D. degree in 1959 from the State University of Iowa College of Medicine and served both his internship and his residency at St. Joseph Hospital, Milwaukee. Doctor Claude has been associated with the Wilkinson Clinic for the past ten years.

Dr. Jahn Joins Quisling Clinic

Dr. Charles L. Jahn has joined the Quisling Clinic in Madison in the department of pediatrics. He is a past associate of *Dr. J. D. Cherry,* Madison, doing a special research study of virus diseases in children as part of a postdoctoral research fellowship at the University of Wisconsin. A graduate of the UW Medical School, he served his internship at Children's Orthopedic Hospital, Seattle, Wash., and spent three years as a pediatric resident at University Hospitals, Madison.

Dr. Rosenberg Named by Yale

Dr. Leon B. Rosenberg, who received his doctor of medicine degree, summa cum laude, from the University of Wisconsin, has been named assistant professor of medicine at Yale University School of Medicine, New Haven, Conn. Since 1959 Doctor Rosenberg has been associated with the National Cancer Institute at the National Institutes of Health, Bethesda, Md. He has received grants from the U.S. Public Health Service and the Hartford Foundation in excess of $100,000 for the genetics section in the Department of Medicine at Yale.

Dr. Meyer to Head Heart Fund Drive

Dr. Ovid O. Meyer, Madison, has accepted the chairmanship of the Wisconsin Heart Association's 1966 Heart Fund campaign, according to James Harrington, Milwaukee, WHA president.

For 19 years Doctor Meyer was chairman of the Department of Medicine at the University of Wisconsin Medical School. In the summer of 1964 he resigned to devote full time to teaching, investigation, and his patients. He is presently co-editor of the "Comments on Treatment" page of the WISCONSIN MEDICAL JOURNAL, and a member of the State Medical Society's Commission on Scientific Medicine. He has served on the American Medical Association Council of Drugs and was chairman of the Section on Internal Medicine.

PHYSICIANS SPEAK AROUND THE STATE

Drs. Joseph Durst and *R. E. Schuldes,* La Crosse, staff obstetricians and gynecologists at Grandview Hospital and the Gundersen Clinic, respectively, on "Birth Control—a Two-Sided Coin," September 2 at a public meeting in La Crosse.

Dr. Patricia Stuff, Bonduel, on "The Growth of a Woman," September 7 before the Women's Association of the First Presbyterian Church in Shawano.

Dr. James Jaeck, Sheboygan, on his specialty, pathology, September 8 at the opening meeting of the Altrusa Club in Sheboygan.

Dr. J. B. Dibble, Eau Claire, on his experiences as a volunteer staff member at a mission hospital in East Africa, September 13 at Neillsville.

Dr. Frank A. Kordecki, Manitowoc, medical director and clinic psychiatrist at the Manitowoc County Mental Health Center, on "The Ingredients of a Wholesome Friendship," at the meeting of the Catholic Woman's Club September 9 in Manitowoc.

Dr. Charles Marks, Milwaukee, on surgical advances in cardiovascular disease, August 2 before the Northwestern chapter of Kiwanis in Fox Point.

PHYSICIAN NEWS *continued*

Dr. Bannister at Chetek

Dr. Fred Bannister began practicing in Chetek July 26 in association with *Drs. R. W. Adams* and *J. E. Powell* at the Chetek Medical Clinic, and at the Lakeside and St. Joseph's Hospitals in Rice Lake. A graduate of the University of Wisconsin Medical School, Doctor Bannister came to Chetek after completing his internship at Los Angeles County Hospital, Los Angeles, Calif.

Doctor Powell left Chetek in September for Macomb, Ill., to accept a position as student health service physician at Western Illinois University. He had been practicing in Chetek since the Medical Clinic was opened in August 1961.

Named to Advisory Councils

Dr. Stanley Berlow, Milwaukee, was one of 12 Wisconsin residents named in August to the Advisory Council for the State Plan for Construction of Facilities for the Mentally Retarded. Among those appointed to the Advisory Council for the State Plan for Construction of Mental Health Centers were *Drs. Leigh M. Roberts* and *Leonard J. Ganser*, Madison, and *Dr. Charles Wunsch*, Green Bay.

State Health Officer *Dr. E. H. Jorris* announced appointment by the State Board of Health of the advisory councils to consult in carrying out the state plans for construction of facilities for the mentally retarded, and for construction of community mental health centers. Enabling legislation to permit Wisconsin to participate in these federal assistance programs was passed by the Legislature and signed into law by Gov. Warren B. Knowles August 3.

Doctor Jorris stated that the Board of Health made its selection of council members from a list suggested by an inter-agency committee composed of representatives of the State Board of Health, the State Department of Public Welfare, the Statewide Planning Committee on Mental Retardation, and the Statewide Planning Committee on Mental Health.

Dr. Shields Opens Schofield Office

Dr. John C. Shields opened an office for the practice of psychiatry late in July at Schofield. A graduate of Syracuse University, Doctor Shields interned at Grace Hospital, Detroit, and completed his psychiatric training at the University of Texas, Galveston. He served for a time as chief psychiatrist at the state hospital in Big Springs, Tex., and was in private practice in Pasadena, Tex., before locating in the Wausau area.

Dr. Mueller Honored

Dr. G. G. Mueller, Princeton, was honored at a surprise birthday dinner in August at White Lake Beach Resort. He also received 600 greeting cards, as well as floral displays.

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Patients on other uricosurics may be transferred to this drug at full dosage.

Contraindications
Active peptic ulcer. Salicylates and citrates antagonize the drug's action and are contraindicated for concomitant use.

Warning
Use with caution in pregnant women.

Precautions
Keep patients under close supervision and make periodic blood counts. Use cautiously in patients sensitive to pyrazoles, in patients with histories of peptic ulcer, and in conjunction with sulfa drugs, the sulfonylurea hypoglycemic agents, and insulin, the actions of which may be potentiated.

In mobilizing urate deposits, the drug may precipitate acute attacks of gout, urolithiasis, and renal colic, especially in the initial stages of therapy. Ensure adequate fluid intake and alkalinize the urine. With renal impairment, test renal function periodically.

Adverse Reactions
The most frequent are upper gastrointestinal disturbances. The drug may activate peptic ulcer. Rash occurs infrequently. Although not reported to date, blood dyscrasias are a possibility.

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*Kuzell, W. C., et al.: Effect of sulfinpyrazone on serum uric acid in gout: a long-term study, Geriatrics 19:894, 1964.

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Dr. Francisco at Tomahawk

Dr. Orlando M. Francisco joined Doctors Inc. at Tomahawk in September in association with *Drs. R. J. Henderson* and *N. L. Bugarin.* Born on the Island of Luzon in the Philippines, he was graduated in 1959 from the University of Santo Tomas at Manila. After successfully completing the Educational Council of Foreign Medical Graduates qualifying examinations, he came to the United States in 1960. He had a rotating internship at Deaconess Hospital, Milwaukee, and finished a three-year approved program in general practice residence, the last year of which he served as chief resident at Deaconess.

Dr. Treffert Named to UW Faculty

Dr. Darold A. Treffert, Fond du Lac, who was appointed superintendent of Winnebago State Hospital in May 1964, has received an appointment to the faculty of the University of Wisconsin Medical School in Madison as clinical instructor in the Department of Psychiatry, *Dr. Peter L. Eichman,* dean, has announced. Doctor Treffert is a graduate of the UW Medical School and completed his psychiatric residency at University Hospitals in 1962.

Wausau Native Helped Check Astronauts

Cdr. Nicholas W. Schmitz, a Wausau native who was graduated from the University of Wisconsin Medical School in 1954 and is now a Navy flight surgeon, was one of ten doctors aboard the aircraft carrier Lake Champlain to take part in the post-recovery medical examinations of Astronauts Gordon Cooper and Charles Conrad after their eight days in outer space.

Dr. Ryan UW Gridiron Physician

Dr. Allan J. Ryan, a native of Brooklyn, N.Y., who has served as attending surgeon at a Meriden, Conn., hospital since 1946, is the new physician for the University of Wisconsin football team. Doctor Ryan, a graduate of Yale and Columbia University College of Physicians and Surgeons, has joined the staff of University Hospitals, Madison. He is a noted authority on athletic injuries and author of a book entitled "Medical Care of the Athlete."

Dr. Stein Elected to AAGP

Dr. B. E. Stein, Madison, has been elected to active membership in the American Academy of General Practice.

Pathologists at River Falls

Drs. Sidney Auerbach and Benjamin W. Lyne, pathologists at Ancker Hospital, St. Paul, announced plans in August for setting up a diagnostic medical laboratory in River Falls. The two planned to maintain their regular schedule at Ancker Hospital, taking care of the laboratory on trips to River Falls.

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PHYSICIAN NEWS *continued*

Dr. Pecarski Opens Practice

Dr. Miodrag Pecarski opened his practice in Dousman September 1. A few days earlier, some 150 persons attended a community get-together at which the Yugoslav physician and his wife and daughter were showered with many household gifts.

Dr. Hinke at Marshfield

Dr. Dayton Hinke has joined the staff of the Marshfield Clinic as a radiologist. After spending 14 years in general practice at Richland Center, he devoted three years to a residency in radiology at Madison. He has an M.D. degree from the University of Pennsylvania. Doctor Hinke interned at Luther Hospital, Eau Claire, and spent one year in the Department of Surgery at the University of Minnesota.

Dr. Gerald A. Kerrigan Named Dean Of Marquette School of Medicine

Dr. Gerald A. Kerrigan, acting dean of Marquette University School of Medicine, Milwaukee, was appointed dean and a member of the medical school board of directors September 15, by Father John P. Raynor, S.J., Marquette president.

Doctor Kerrigan, 44, became acting dean last February succeeding *Dr. John S. Hirschboeck.*

A 1946 graduate of Harvard University Medical School, he has been on the Marquette medical faculty since 1956 and is an attending physician at Milwaukee Children's hospital. He is a professor in the department of pediatrics. He lives at 1081 E. Circle Dr., Whitefish Bay, with his wife, three daughters, and a son.

Father Raynor also announced that Louis J. Selzer, president of Selzer–Ornst Company, and Evan P. Helfaer, former chairman of the board of Lakeside Laboratories, have been elected directors of the school of medicine. They fill vacancies left by the resignations of F. S. Cornell, who retired this year as executive vice-president of A. O. Smith Corporation, and Atty. Walter H. Bender.

Dr. Gamber Tegtmeyer, medical director Northwestern Mutual Life Insurance Company, was reelected a director.

The 13-member board controls the Marquette School of Medicine as a corporation separate from the rest of the university. Five directors, including Fr. Raynor, are from the university. The other eight are laymen.

Doctors Aid Migrant Clinic

Dr. Peter Groessl, Green Bay, and *Dr. D. E. Dorchester,* Sturgeon Bay, provided their services free of charge during the summer at the free migrant medical clinic at Sturgeon Bay.

Dr. Handeyside Leaves Palmyra

After practicing at Palmyra for 16 years, *Dr. R. G. Handeyside* closed his office in that community September 30 to become associated with *Dr. S. F. Vognar* in Fort Atkinson.

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Wausau City Health Department, Wausau, Wisconsin
West Allis City Health Department, West Allis, Wisconsin

PHYSICIAN NEWS *continued*

Grant to University of Wisconsin

Warner–Lambert Research Institute has made an $8,000 grant to the University of Wisconsin to support a graduate training program in pharmaceutical analytical research. Dr. Theodore I. Fand, Warner–Lambert's Director of Pharmaceutical Research and Development, said, "The growing complexity of drug research and the increased sophistication in technology have created a critical need for more and better trained personnel. We believe that such support assures the continuing availability of safe and effective medication." The funds are intended to help train doctoral candidates in the field of pharmaceutical analysis. An expanded research and training program has been recently launched in this area at the school's Madison campus.

Dr. Blahnik Health Officer

Dr. C. L. Blahnik was appointed health officer of the city of Peshtigo in August replacing *Dr. Antoine Barrette.* Doctor Blahnik is also county coroner.

Dr. Day at Wausau

The Wausau Clinic announces the association of Dr. K. L. Day in the practice of urology. Doctor Day is a graduate of the State University of Iowa College of Medicine and recently completed his residency in urology at the Veterans Administration Hospital, Wood, and Milwaukee County.

Dr. Moody Conducts Program

When the annual tuberculin skin-test was offered to students of the Butternut school September 8, *Dr. L. W. Moody* was in charge. Doctor Moody is superintendent and medical director of Purcair Sanatorium at Bayfield.

Dr. Uhrich Serves

Dr. Gerard Uhrich, La Crosse physician who is a lieutenant colonel in the 153rd Engineer Battalion, South Dakota National Guard, was with the outfit for two weeks of field training in the Black Hills in August.

Dr. Hartridge Elected

Dr. T. L. Hartridge is the newly elected president of Methodist Hospital's medical staff, Madison. Immediate past president is *Dr. L. S. Kellogg. Dr. D. W. Hurst* is prsident-elect and *Dr. J. P. Keepman,* secretary-treasurer.

Jackson Foundation Board Changes

At the recent annual meeting of the board of directors of The Jackson Foundation for Medical Education and Research the resignations of two of the directors, *Dr. George H. Ewell* and Mr. Harold R. Heberlein were accepted. Both had served as directors since incorporation of the foundation in 1947. To replace them, *Dr. John H. Morledge* and Mr. John L. Garrett were elected directors. Other directors and members include: *Dr. Luther E. Holmgren, Dr. William B. Parsons, Jr.,* Mrs. Lora Jackson, Professor Harry Steenbock, and Attorney William Jackman. Doctor Holmgren was reelected president and Doctor Parsons, vice-president. Doctor Morledge was elected secretary and Mr. Garrett, treasurer. Doctor Parsons, who serves as director of research for the foundation, presented a report on recent progress and future goals in the research program.

Photo courtesy EAU CLAIRE TELEGRAM

SACRED HEART HOSPITAL, Eau Claire, is the sixth hospital in Wisconsin to be granted the Achievement Award of the State Medical Society. Sister M. Patrice, hospital administrator, received the award from Dr. George B. Murphy, Jr., La Crosse, at ceremonies held September 8 at the hospital. Previous recipients of the award were: Milwaukee Children's Hospital, Milwaukee, and Lakeside Methodist Hospital, Rice Lake, in 1960; St. Joseph's Hospital, Hillsboro, and St. Luke's Hospital, Racine, 1961, and Hayward Area Memorial Hospital, Hayward, in 1962.

Sacred Heart Hospital, Eau Claire, Receives SMS Achievement Award

Sacred Heart Hospital, Eau Claire, received the State Medical Society's 1965 Achievement Award at a dinner meeting on September 8 in the hospital's Viking Room. Presenting the award to Sister M Patrice, hospital administrator, was *Dr. George B. Murphy, Jr.,* La Crosse, chairman of the SMS Commission on Hospital Relations and Medical Education, who said it was given for "extraordinary and unusual achievement" and for "great effort and great accomplishment in serving the medical needs of a community."

Sister Patrice, in accepting the award, noted that much of the credit for the hospital's achievement goes back to the pioneers who started the institution in the logging community 75 years ago.

Dr. Ralph C. Frank, Eau Claire, nominated the hospital for the award while he was a member of the SMS Council. Current Council member from Eau Claire is *Dr. Walton R. Manz.*

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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OBITUARIES

Dr. Walter Will Crockett, dean of Beloit area physicians and surgeons, died at his home in Beloit July 16, 1965, at the age of 96. Only eight days before his death, the BELOIT DAILY NEWS had recognized his nearly 70 years of service with an article, "Patients Remember Dedication of Beloit Area's Oldest Doctor."

Born on a farm near Seward, Ill., Doctor Crockett enrolled in 1892 in Northwestern University's first four-year course in medicine. Following his graduation in 1896 he practiced in Roscoe, Ill. Since 1903 he had practiced in Beloit, full time until the end of 1958 and part time in his home from then on until this year. In 1903 he also became a member of the Rock County Medical Society. Since 1948 he had been a member of the 50 Year Club of the State Medical Society of Wisconsin, which granted him life membership in 1949. He was also a member of the American Medical Association and the American Association of Railway Surgeons.

From 1905 to 1907 Doctor Crockett served as Beloit city health officer and it was through his efforts that all milk cows around Beloit were tested for tuberculosis. He was also responsible for instigating vaccinations in the Beloit public schools. For 15 years Doctor Crockett was chief of staff of the old H. B. Strong Emergency Hospital and when Beloit Memorial Hospital was established and opened he was its first staff president. During World War I he served in the Volunteer Medical Corps.

Surviving are his widow, Grace; a son, David W., Rockton, and two daughters, Mrs. W. Lloyd Kenny of Chicago and Mrs. George Mason of Dania, Fla. A son, Russell, preceded his father in death.

Dr. Otto H. Foerster, 89, who was one of the organizers and founders of the WISCONSIN MEDICAL JOURNAL in 1903 and its assistant editor for seven years, died July 18, 1965, at Columbia Hospital, Milwaukee. One of the group who founded that hospital in 1909, he was a dermatologist there for 50 years and had served as chief of staff. He had also been a member of the staff at Milwaukee Hospital and the consulting staff at Milwaukee Children's Hospital.

A native of Milwaukee, Doctor Foerster received his medical degree in 1898 from the University of Pennsylvania. Following his graduation he volunteered for service in the Spanish–American War, in which he served as chief hospital steward of the Fourth Wisconsin Volunteer Infantry. In 1899 he interned at Howard Hospital in Philadelphia and from 1900 to 1901 he served a residency at the University of Vienna, Austria.

In World War I Doctor Foerster was a captain in the Army Medical Corps at Camp Greenleaf and Camp Gordon, Ga.

From 1925 to 1946 he was professor of dermatology at the University of Wisconsin Medical School, Madison, where he was an emeritus professor at the time of his death. He practiced in Milwaukee until 1964.

Doctor Foerster was a member and past president of the Milwaukee Academy of Medicine and the Chicago Dermatological Society and an honorary member and past president of the American Dermatological Association. He also held honorary membership in The Medical Society of Milwaukee County, which he joined in 1902, and the State Medical Society of Wisconsin, of whose 50 Year Club he became a member in 1953. He was a member of the American Academy of Dermatology and Syphilology and the American Medical Association and a past president of the AMA Section on Dermatology. In 1962 in Washington he was selected as one of 12 honorary vice-presidents of the 12th International Congress of Dermatology.

Surviving are his widow, Louise; a daughter, Mrs. Dean (Frances) Echols, New Orleans, La.; a son, Dr. Frederick E., Milwaukee, and a brother, Dr. Harry R., Milwaukee.

Dr. Lawrence C. Sass, a Milwaukee obstetrician and gynecologist who was on the staff of St. Luke's and St. Michael Hospitals, died at St. Luke's July 21, 1965, at the age of 55. He is survived by his widow, Lu Eva, and three children.

Doctor Sass received his M.D. degree in 1933 from Creighton University, Omaha, Neb. His internship was served at St. Alexis Hospital, Cleveland, O., and his residency at Milwaukee General Hospital. He had practiced in Milwaukee since 1935.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Obstetrical–Gynecological Society, and the American College of Obstetricians and Gynecologists.

Dr. Wilson S. Dunn, 33, medical director of the Dane County Mental Health Center, died July 22, 1965, in Madison. A staff psychiatrist at the center since November 1962, Doctor Dunn assumed the duties of medical director Apr. 1, 1964.

Doctor Dunn, who was born at Cedar Rapids, Ia., was a 1958 graduate of the University of California Medical School at Berkeley. He served a one-year internship at the University of Iowa Hospitals in Iowa City and a three-year residency in psychiatry at University of Wisconsin Hospitals, Madison.

He is survived by his widow, who is also a psychiatrist, and two children, Caitlin and Max.

Doctor Dunn was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Lawrence D. Quigley, 67, a practicing physician and surgeon in Green Bay since 1924, died July 24, 1965, in Green Bay, his native community.

OBITUARIES *continued*

A graduate of Marquette University School of Medicine, Milwaukee, he interned at Milwaukee County Hospital from July 1, 1923, to June 30, 1924. He was named a fellow of the American College of Surgeons in 1936 and was a founder member of the Wisconsin Surgical Society. He had been a longtime examiner for the U.S. Employes Compensation Commission. He was a member of the Brown County Medical Society and a former president of the Brown–Door–Kewaunee County Medical Society (now two separate societies, the Brown and Door–Kewaunee), and a member of the State Medical Society of Wisconsin and the American Medical Association.

His widow, Eleanor, survives, along with two sons, Lawrence, Red Bank, N.J., and Richard, Interlaken, N.J., and one daughter, Mrs. Thomas Harder, Brookfield.

Dr. Karl F. Schlaepfer, 77, former Milwaukee physician and resident of Shorewood, died Aug. 1, 1965, in Cuernavaca, Mexico, where he had lived since his retirement in 1960. He was a former chief of the surgical department at Evangelical Deaconess Hospital in Milwaukee.

Born in Brig, Switzerland, Doctor Schlaepfer received his medical degree in 1911 from the University of Zurich and served his internship and residency at Kantonsspital, Muensterlingen, Switzerland. Before coming to the United States he served as an assistant in surgical clinics in Leipzig and Vienna and as an associate in surgery and resident surgeon at a surgical clinic in Zurich. From 1921 to 1923 he was an associate in surgery and assistant resident surgeon at Johns Hopkins Medical School in Baltimore and for the two years following, he was an instructor in pathology at Yale Medical School. From 1925 to 1927 he was an instructor in surgery at Marquette University School of Medicine.

He was licensed in Wisconsin in 1925 and became director of the laboratory and department of clinical pathology at Deaconess in 1928. He also served on the staffs of Milwaukee Children's Hospital, Johnston Emergency, Columbia, St. Michael and St. Joseph's Hospitals.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and its 50 Year Club, and the American Medical Association. He was also a fellow of the International College of Surgeons and a past secretary of the Wisconsin Section of its U.S. Chapter, a diplomate of the National Board of Medical Examiners, and a past president of the Wisconsin Academy of Surgery.

He is survived by his widow, Helen, who is staying with one of their sons, Karl, Jr., in Fullerton, Calif., and two other sons, Fred, Sunnyvale, Calif., and William, New York City.

Dr. James L. Wardlaw, Jr., 52, assistant Wisconsin state health officer since July 1 of this year, died Aug. 16, 1965, at a Madison hospital. He had been a member of the staff of the Wisconsin State Board of Health since January 1961, when he assumed the position of director of the section on community health services.

Doctor Wardlaw represented the State Department in meetings of the State Society's divisions on nervous and mental diseases, school health, and maternal and child welfare of the Commission on State Departments.

Prior to locating in Wisconsin, Doctor Wardlaw was director of the Monroe County Health Department at Key West, Fla. He had served with the Florida State Board of Health for 11 years.

Born at Cristobal, Canal Zone, Doctor Wardlaw obtained his M.D. degree at New York University and a master's degree in public health at the University of North Carolina. His internship was served at Gorgas Hospital, Ancon, Canal Zone, and his residency at Colon Hospital, Cristobal.

He was a diplomate of the American Board of Preventive Medicine and a fellow of the American Public Health Association. He was also a member of the American College of Preventive Medicine, the American Association of Public Health Physicians, the Wisconsin Association for Public Health, and the Association of Military Surgeons. He had served from August 1942 until May 1946 as a medical officer in the U.S. Army.

His widow, Anita, and four daughters survive.

* * *

AUDIO-DIGEST ISSUES NEW LIBRARY OF TAPE RECORDINGS

A library of more than 300 one-hour tape recordings, devoted to comprehensive discussions of everyday office problems by leading specialists, has just been released to the medical profession by the Audio-Digest Foundation, Los Angeles.

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Many of the recordings represent carefully-edited, on-the-spot reports from several hundred major meetings of such groups as the American Medical Association, American College of Physicians, American Society of Anesthesiologists, American College of Obstetricians and Gynecologists, as well as condensations of major university postgraduate courses.

The Catalog of Classics is available free of charge and may be obtained by writing the Foundation Editorial Offices at 619 S. Westlake Avenue, Los Angeles 90057.

Recent Wisconsin Licentiates

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, January 12, 13, 14, 1965.

Name	*School of Graduation*	*Year*	*City*
Albertini, Richard J.	University of Wisconsin	1963	Madison
Becker, George E.	University of Wisconsin	1963	Madison
Boeker, Allen J.	University of Wisconsin	1963	Richmond, Ky.
Brish, Adam	Lodz Medical School	1952	North Quincy, Mass.
Colquhoun, Joseph	University of London	1949	Cleveland Heights, O.
Elston, Asaph C. V.	University of Wisconsin	1964	La Crosse
Engel, Charles H.	University of Wisconsin	1964	Brillion
Evangelista, Teofilo L.	Santo Tomas University	1952	Minneapolis, Minn.
Ferrou, Carlos A.	University of Buenos Aires	1931	Milwaukee
Floch, Louis John	University of Manitoba	1956	Milwaukee
Gager, Walter E.	Marquette University	1963	Milwaukee
Geimer, Nicholas F.	University of Wisconsin	1963	Great Lakes, Ill.
Gharib, Reza	Tehran University	1954	Fond du Lac
Hargis, Edward L.	University of Oregon	1963	Madison
Harper, David G.	University of Wisconsin	1963	Edgewood Arsenal, Md.
Grill, Karl Peter	University of Wisconsin	1964	Wausau
Guten, Gary N.	University of Wisconsin	1964	Milwaukee
Heinen, Robert D.	University of Wisconsin	1964	La Crosse
Henke, Timothy K.	University of Wisconsin	1963	Madison
Honish, John S.	University of Wisconsin	1964	Oconto
Hyde, Howard P.	Duke University	1964	Fort Worth, Tex.
Jefferson, James W.	University of Wisconsin	1964	Madison
Kolmeier, Karl H.	University of Muenster	1959	Rochester, Minn.
Koop, Richard H.	Marquette University	1964	Detroit, Mich.
Lambert, Milton B.	University of Wisconsin	1964	San Antonio, Tex.
Margolis, Lawrence W.	University of Wisconsin	1964	San Francisco, Calif.
Mercado, Roger C.	University of Santo Tomas	1958	Kenosha
Neesvig, Burton O., Jr.	University of Wisconsin	1964	Chicago, Ill.
Nuyda, d'Jahlma A.	University of Santo Tomas	1956	Milwaukee
Perna, Giuseppe	University of Siena	1958	Madison
Pohle, Edward L.	University of Wisconsin	1963	Madison
Remeniuk, Eudokia	University of Bonn	1953	Chicago, Ill.
Salazar, Guillermo R.	University of Havana	1944	Wood
Sanz, Carlos Jose	University of Havana	1944	Wood
Scheckler, William E.	University of Pennsylvania	1964	Madison
Sybers, Harley D.	University of Wisconsin	1963	Madison
Tibbetts, Palmer G.	University of Wisconsin	1964	Milwaukee
Topetzes, Gregory J.	Marquette University	1961	Milwaukee
Wagelie, Reuben G.	University of Philippines	1956	Beloit
Wegner, Gene P.	University of Wisconsin	1963	Madison
Wilson, Donald H.	McGill University	1956	Hanover, N.H.

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 23, 1965.

Arnesen, Richard B.	Western Reserve University	1963	McFarland
Bauman, Martin H.	Northwestern University	1959	Madison
Blank, Richard J.	Marquette University	1964	Wausau
Brooker, Warren J.	University of Iowa	1945	Duluth, Minn.
Cox, Gordon Lee	New York University	1963	Madison
de Lamerens, Sergio	University of Havana	1953	Milwaukee
Delta, Basil G.	University of Istanbul	1952	Milwaukee
Dillard, Andrew G.	University of Texas	1960	Marshfield
Drexler, Charles J.	Creighton University	1958	Eau Claire
Dzubay, Joseph J.	Creighton University	1964	Madison
Fischer, Herbert K. J.	Eberhardt Karl University	1951	Marshfield
Garber, Richard D.	Ohio State University	1964	Oseo
Haller, Carol A. Klepinger	Indiana University	1958	Milwaukee
Harris, Theodore A.	University of Manitoba	1952	Wauwatosa
Henningsen, John T.	University of Nebraska	1962	Rice Lake
Holl, John W.	Northwestern University	1964	Milwaukee
Johnson, Rodney C.	University of Minnesota	1961	Sheboygan
Kalkhoff, Ronald	Washington University	1960	Milwaukee
Keller, Kent E.	Washington University	1961	Madison
Kullerstrand, Donald S.	University of Illinois	1961	Detroit, Mich.
Maddix, Bill L.	University of Kansas	1961	Monroe
Mantione, Mary Ethel	Loyola University	1960	Waukegan, Ill.
May, James E.	Northwestern University	1963	Milwaukee
Miks, George M.	Marquette University	1963	Ely, Minn.
Norfleet, Robert G., III	University of Colorado	1957	Marshfield
Pflaum, Francisco E.	University of Buenos Aires	1945	Portland, Me.
Thomas, Griffith L.	Loma Linda University	1964	Prentice
Waterhouse, Blake E.	Indiana University	1961	Rochester, Minn.
Wolfarth, Alfred	Loyola University	1927	Iron Ridge

Anatomy of
Low Back Pain #1

the sedentary life is often the seat of low back pain

The human spine is not engineered fo prolonged sitting at desks, pianos, type writers and drafting boards. The stresse set up by the heavy, forward-tilted hea and trunk, balanced precariously on a insufficient base, result in strain of th dorsal musculature, particularly at th low lumbar level.

The unusual muscle-relaxant and anal gesic properties of 'Soma' make it espe cially useful in the treatment of low bac sprains and strains. 'Soma' is widel prescribed ☐ **to relieve pain** ☐ **to rela muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management c muscle spasm, pain, and stiffness in a variety c inflammatory, traumatic, and degenerative musc loskeletal conditions. It also may act to normaliz motor activity in certain neurologic disturbance

Contraindications: Allergic or idiosyncratic rea tions to carisoprodol.

Precautions: 'Soma', like other central nervo system depressants, should be used with cautio in patients with known propensity for taking e cessive quantities of drugs and in patients wit known sensitivity to compounds of similar chem cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with ar frequency is sleepiness, usually on higher tha recommended doses. An occasional patient m not tolerate carisoprodol because of an individu reaction, such as a sensation of weakness. Oth rarely observed reactions have included dizzines ataxia, tremor, agitation, irritability, headache, i crease in eosinophil count, flushing of face, ar gastrointestinal symptoms.

One instance each of pancytopenia and leuk penia, occurring when carisoprodol was admi istered with other drugs, has been reported, as h an instance of fixed drug eruption with carisoprod and subsequent cross reaction to meprobamat Rare allergic reactions, usually mild, have includ one case each of anaphylactoid reaction with mi shock and angioneurotic edema with respirato difficulty, both reversed with appropriate therap In cases of allergic or hypersensitivity reaction carisoprodol should be discontinued and approp ate therapy initiated. Suicidal attempts may pr duce coma and/or mild shock and respirato depression.

Dosage: Usual adult dose is one 350 mg. tabl three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white table and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

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1965 **Wisconsin**

Oct. 29–30: Symposium on integration of social science concepts in psychotherapy, sponsored by Milwaukee Psychiatric Hospital through Marquette University School of Medicine, Holiday Inn Central, Milwaukee.

Nov. 4: "In Depth" teaching program, "Problems Encountered in Aging Process" (Psychiatric), sponsored by University of Wisconsin Medical School, State Medical Society, and Madison Chapter of Wisconsin Academy of General Practice, SMS headquarters, Madison.

Nov. 4–5: Symposium on epilepsy, auspices of Department of Neurology, University of Wisconsin Medical School, Wisconsin Center, Madison.

Nov. 4, 11, 18–Dec. 2: Course in fluid and electrolyte therapy given by Marquette University School of Medicine in cooperation with Milwaukee Children's Hospital, Amphitheater, Milwaukee Children's Hospital, 1700 W. Wisconsin Ave., Milwaukee.

Nov. 10: Annual Dearholt Day Lectures by Dr. Stanford Wessler; 12:30 p.m. Coffey Auditorium, Milwaukee County General Hosepital, Milwaukee; 4 p.m. auditorium of Service Memorial Institute, University of Wisconsin, Madison.

Nov. 11–13: The Medical Society of Milwaukee County, Milwaukee medical conference, Coffey Auditorium, Milwaukee County Hospital.

Nov. 12–14: Wisconsin Society of Pathologists, annual meeting, held jointly with North Central Region of College of American Pathologists, Wisconsin Society of Medical Technologists and Wisconsin Radiological Society, Marquette University, Mamie's Grotto, and Coach House Motor Inn, Milwaukee.

Nov. 19: Mount Sinai Hospital, 4th annual medical-industrial symposium, Hotel Pfister Grand Ballroom, Milwaukee.

Dec. 1: "In Depth" teaching program, "Problems Encountered in Aging Process" (Medicine), SMS headquarters, Madison.

1966

Jan. 20: "In Depth" teaching program, "Problems of Elderly Patients" (Surgery and Anesthesia), SMS headquarters, Madison.

Feb. 16: "In Depth" teaching program, "Problems of Elderly Patients" (Dermatology and EENT), SMS headquarters, Madison.

Mar. 9, 16, 23, 30: Marquette University School of Medicine, postgraduate course in hematology, Milwaukee.

Mar. 24: "In Depth" teaching program, "Problems of Elderly Patients" (Neurology), SMS headquarters, Madison.

Mar. 31–Apr. 2: University of Wisconsin Medical School, postgraduate program on "Viruses and Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 7, 14, 21, 28: Marquette University School of Medicine, postgraduate course on chemotherapy of infectious diseases, Milwaukee.

May 5–7: University of Wisconsin extension division, "Radiology and Pathology of Genitourinary System," Wisconsin Center, Madison.

May 10–12: State Medical Society, annual meeting, La Crosse.

May 21: Wisconsin Heart Association, 18th annual meeting, Wisconsin Center, Madison.

June 17: Wisconsin Academy of General Practice, Lederle symposium, Wausau Club, Wausau.

June 2–4: University of Wisconsin Extension Division, psychiatric program, Wisconsin Center, Madison.

1965 **Neighboring States**

Oct. 20, Nov. 3, 17, Dec. 1, 15: Mount Sinai Hospital Medical Center of Chicago, symposium on management of chronic disease patient, sponsored by USPHS at Mount Sinai Hospital, Chicago.

Oct. 28–30: American College of Obstetricians and Gynecologists, District VI meeting, Kahler Hotel, Rochester, Minn.

Oct. 30–Nov. 5: Annual otolaryngologic assembly of Department of Otolaryngology of University of Illinois College of Medicine, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Nov. 5: International College of Surgeons, divisional meeting, Urbana, Ill.

Nov. 10–13: American College of Obstetricians and Gynecologists, District VI conference on obstetric, gynecologic, and neonatal nursing, Pick–Congress Hotel, Chicago, Ill.

Nov. 11–13: Ancker Hospital (Saint Paul–Ramsey Hospital), inaugural scientific program including two days of general medical meetings and one-half day specialty meetings, St. Paul, Minn.

Nov. 12: Diabetes Association of Greater Chicago, 8th annual symposium on diabetes, Bigler Auditorium, Children's Memorial Hospital, Chicago.

Nov. 19–22: National Society for Crippled Children and Adults, annual convention, Palmer House, Chicago, Ill.

1966

Mar. 21–Apr. 2: Department of Otolaryngology of Illinois Eye and Ear Infirmary and College of Medicine of University of Illinois at the Medical Center, Chicago, postgraduate course in laryngology and bronchoesophagology, at Illinois Eye and Ear Infirmary.

1965 **AMA**

Nov. 28–Dec. 1: AMA 19th clinical convention, Philadelphia, Pa.

1966

Feb. 4–9: AMA Medical Education Congress.

June 26–30: AMA Annual Convention, Chicago.

Nov. 27–30: AMA Clinical Convention, Las Vegas.

Psychotherapy Symposium in Milwaukee

A symposium on integration of social science concepts in psychotherapy will be sponsored by the Milwaukee Psychiatric Hospital, through Marquette University School of Medicine, Friday and Saturday, October 29 and 30, at the Holiday Inn Central, Milwaukee.

Guest speakers on the program will be A. B. Hollingshead, Ph.D., professor and chairman, Department of Sociology, Yale University, "Social Class in American Society;" Otto Pollak, Ph.D., professor of sociology, Wharton School of Finance and Commerce, University of Pennsylvania, "Social Change and Psychotherapy;" Zachary Gussow, Ph.D., associate professor (anthropology), Department of Psychiatry, Louisiana State University; "The Doctor-Patient Relationship in Psychoanalysis and Psychotherapy;" Aaron Stern, M.D., Ph.D., psychoanalyst, associate in psychiatry, Columbia University Psychoanalytic Clinic for Training and Research, "Social Goals in Psychotherapy;" and Kenneth B. Clark, Ph.D., director, Social Dynamics Research Institute of the City University of New York, "Minority Status and Some Problems of Psychotherapy."

Program moderator will be Lewis Bernstein, Ph.D., professor and head, psychology section, Department of Psychiatry, Marquette. A welcome will be extended and introductory remarks made Friday morning by Dr. B. Cullen Burris, medical director

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of Milwaukee Psychiatric Hospital; Dean K. Roe, the hospital's administrator; Dr. Gerald A. Kerrigan, dean of the MU School of Medicine; and Dr. Raymond Headlee, professor and acting chairman, Department of Psychiatry, Marquette.

The final hour of the program, from 11 a.m. until noon Saturday, will be devoted to a panel discussion and summary by Doctors Hollingshead, Pollak, Gussow, Stern, and Clark.

The registration fee of $10.00 will include luncheon on Friday.

Postgraduate Course in Chicago

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from Mar. 21 through Apr. 2, 1966. The course is limited to 15 physicians and will be under the direction of Dr. Paul H. Holinger. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants are asked to write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Viruses and Clinical Pediatrics Course

The University of Wisconsin Medical School announces a postgraduate program on "Viruses and Clinical Pediatrics" to be held Mar. 31–Apr. 2, 1966, at the Wisconsin Center, Madison.

The program is designed to give physicians a basic understanding of the mechanism of virus infections and their importance in clinical diseases of children. Emphasis the first day will be on basic information, with the following day and a half devoted to discussion of the newer knowledge of clinical virological problems and related therapeutic implications.

Guest faculty will include Dr. Saul Krugman, professor and chairman, Department of Pediatrics, New York University School of Medicine; Dr. Samuel L. Katz, assistant professor of pediatrics, The Children's Hospital Medical Center, Boston; and Dr. Marc O. Beem, associate professor of pediatrics, University of Chicago. Included in the Wisconsin faculty are Dr. Alfred Evans and Elliot Dick, Ph.D., of the University of Wisconsin Medical School's Department of Preventive Medicine.

For more complete information, contact: Thomas Meyer, M.D., Director, Postgraduate Medical Education, Extension Division, Room 401, University of Wisconsin, Madison.

IX International Cancer Congress

In connection with the IX International Cancer Congress, which will take place Oct. 23–29, 1966, in

Tokyo, Japan, a charter flight and several group flights are contemplated, thus substantially reducing the cost of transportation. Members of the immediate family of congress participants will be eligible.

Anyone interested should communicate with Hirsch Marks, M.D., 435 East 57th St., New York, N.Y. 10022.

ISRD Congress To Be Held in Germany

The tenth world congress of the International Society for Rehabilitation of the Disabled, New York, is to be held at Rhein-Main-Hall, Wiesbaden, Germany, Sept. 11–17, 1966, it is announced by Sumner G. Whittier, executive director of the National Society for Crippled Children and Adults, Chicago, United States member of the International Society. Theme will be "The Industrial Society and Rehabilitation: Problems and Solutions."

Dr. Heinrich Lübke, president of the Federal Republic of Germany, has accepted the patronage for this congress. President of the congress is Dr. K. Lindemann, chairman of the Deutsche Vereinigung fur die Rehabilitation Behinderter, which is the affiliated national member organization of the ISRD and as such the representative for Germany.

The International Society counts national associations and organizations from 60 countries among its affiliated and associate members. The Congress will aim at finding ways to improve job placement and rehabilitation programs for the handicapped, the disabled, and the sick throughout the world.

FIFTH ANNUAL MILWAUKEE MEDICAL CONFERENCE

Thursday, Friday and Saturday—November 11, 12 and 13, 1965

Coffey Memorial Auditorium—Milwaukee County Hospital

Sponsored by The Medical Society of Milwaukee County in cooperation with the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin; Marquette University School of Medicine and its teaching hospitals; Milwaukee County Hospital Intern-Resident Association; Marquette University Medical Alumni Association; and the University of Wisconsin Medical Alumni Association.

REGISTRATION OPEN TO ALL PHYSICIANS. No registration fee. Acceptable for 16 credit hours by American Academy of General Practice.

PROGRAM

THURSDAY, NOVEMBER 11

Morning Session

8:30 REGISTRATION—Coffee will be served, Lobby, 2nd floor entrance, and stage entrance to Coffey Auditorium.
Registration will continue throughout the program.

DIAGNOSIS BY SPECIAL TECHNIQUE
Demonstration and Exhibits (Coffey Auditorium Foyer and Second Floor Corridor)

Abdominocentesis, *Larry C. Carey, M.D.* Instructor in Surgery, Marquette University School of Medicine

Pleural Biopsy, *Jack R. Hoffman, M.D.* Clinical Instructor in Medicine, Marquette University School of Medicine

Percutaneous Hepatic Cholangiography, *James E. Bell, M.D.* Instructor in Radiology, Marquette University School of Medicine

Renal Biopsy, *Joseph A. Beres, M.D.* Assistant Professor of Medicine Marquette University School of Medicine

Small Bowel Aspiration Biopsy, *Konrad H. Soergel, M.D.* Assistant Professor of Medicine, Marquette University School of Medicine

Ultrasound, *Anthony Sances, Jr. Ph.D.* Assistant Professor of Neurosurgery, Marquette University School of Medicine

Blood Gas Studies, *David J. Rosenschweig, M.D.* Instructor in Medicine, Marquette University School of Medicine

Central Venous Pressure, *William E. Evans, M.D.* Assistant Clinical Instructor in Surgery, Marquette University School of Medicine

Arterial Puncture, *Ross C. Kory, M.D.* Professor of Clinical Research in the Department of Medicine, Marquette University School of Medicine.

Conference Presiding: *Robert F. Purtell, M.D.*, President of The Medical Society of Milwaukee County

9:45–10:00 Welcome—*Harold E. Cook, M.D.*, Director of Medical Services, Milwaukee County General Hospital
Gerald A. Kerrigan, M.D., Dean, Marquette University School of Medicine
Robert F. Purtell, M.D.

10:00–10:30 Cinefluorography and Tomography, in Diagnosis, *Charles M. Nice, Jr., M.D.*, Professor and Chairman, Department of Radiology, Tulane University School of Medicine

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to be so tired...

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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10:30–10:45 Skin Examination—An Aid in Diagnosis, *William B. Bean, M.D.*, Professor of Medicine, Head, Department of Internal Medicine, University of Iowa Hospitals

10:45–11:00 Tumor Aspiration—A Diagnostic Technique, *Thomas W. Botsford, M.D.*, Assistant Clinical Professor of Surgery, Harvard Medical School

11:00–11:30 Special Tests in Renal Hypertension, *Norman G. Levinsky, M.D.*, Associate Professor of Medicine, Boston University School of Medicine

11:30–12:00 The Role of Lactic Dehydrogenase Iso-enzymes in Diagnosis, *Daniel P. Collins, M.D.*, Clinical Instructor in Pathology, Marquette University School of Medicine

THURSDAY AFTERNOON

General Session

Presiding: *Eugene G. Collins, M.D.*, President-Elect, The Medical Society of Milwaukee County

1:15– 1:45 The Importance of Diagnosis in Modern Medical Science, *Jack D. Myers, M.D.*, Professor and Chairman, Department of Medicine, University of Pittsburgh School of Medicine

1:45– 2:15 The Role of Physical Diagnosis in Modern Medical Science, *William B. Bean, M.D.*

2:15– 2:45 The Role of History Taking in Modern Medical Science, *Thomas W. Botsford, M.D.*

2:45– 3:15 Routine Laboratory Tests—The Sign of Progress?, *Norman G. Levinsky, M.D.*

3:15– 3:30 Coffee Break

3:30– 4:00 Routine X-ray Studies—A Complete Workup?, *Charles M. Nice, Jr., M.D.*

4:00– 5:00 Screening Clinics in the Practice of Medicine, Moderator: *Robert F. Purtell, M.D.*

Panel: *Richard P. Jahn, M.D.*, Associate Professor of Medicine, Marquette University School of Medicine, Medical Director, Wisconsin Anti-Tuberculosis Association; *E. R. Krumbiegel, M.D.*, Head and Professor of Public Health, Marquette University School of Medicine; *Thomas W. Botsford, M.D., Norman G. Levinsky, M.D., Jack D. Myers, M.D., William B. Bean, M.D.*

6:00 Wisconsin Academy of General Practice Dinner Meeting Sponsored by The Milwaukee Academy of General Practice—Blue Mound Country Club

FRIDAY, NOVEMBER 12

SPECIAL SESSION

Diagnosis at the Bedside

8:30–10:00 Ward Rounds with Guest Faculty

Conference Presiding: *J. C. Peterson, M.D.*, Professor and Chairman, Department of Pediatrics, Marquette University School of Medicine

10:00–11:00 Diagnosis of the Pediatric Patient, *Sergio deLamerens, M.D.*, Assistant Professor of Pediatrics, Marquette University School of Medicine; *Harold I. Dobbs, M.D.*, Instructor in Pediatrics, Marquette University School of Medicine; *June M. Dobbs, M.D.*, Assistant Professor of Pediatrics, Marquette University School of Medicine

11:00– 1:00 Open House—Departments of Surgery, Medicine, Pediatrics, Gyn-Ob, Pathology

FRIDAY AFTERNOON

DIAGNOSTIC CONSIDERATIONS—ORGANS—SYSTEMS—REGIONS

Presiding: *Howard M. Klopf, M.D.*, President, Wisconsin Academy of General Practice

1:00– 1:30 The Clinical Diagnosis of Renal Disease, *Norman G. Levinsky, M.D.*

1:30– 2:00 The Surgical Abdomen, *Thomas W. Botsford, M.D.*

2:00– 2:30 Physical Signs in Cardiovascular Disease, *Jack D. Myers, M.D.*

2:30– 3:00 The Diagnosis of Esophageal Diseases, Moderator: *Konrad H. Soergel, M.D.*

Panel: *L. W. Worman, M.D.*, Assistant Professor of Thoracic and Cardiovascular Surgery, Marquette University School of Medicine; *Charles M. Nice, Jr., M.D., Daniel H. Winship, M.D.*, Assistant Professor of Medicine, Marquette University School of Medicine

3:00– 3:15 Coffee Break

3:15– 3:30 Diagnosis of Non-fatal Pulmonary Embolism, *Donald P. Schleuter, M.D.*, Instructor in Medicine, Marquette University School of Medicine

3:30– 4:00 Diagnosis of Indeterminate Pulmonary Lesions, *William W. Stead, M.D.*, Professor of Medicine, Marquette University School of Medicine

4:00– 5:00 Diagnosis of Metabolic Disorders, Moderator: *William W. Engstrom, M.D.*, Professor and Chairman, Department of Medicine, Marquette University School of Medicine

Panel: *Jack D. Myers, M.D., Norman H. Engbring, M.D.*, Associate Professor of Medicine, Marquette University School of Medicine; *John R. Petersen, M.D.*, Assistant Professor of Medicine, Marquette University School of Medicine; *Edwin H. Ellison, M.D.*, Professor and Chairman, Division of Surgery, Marquette University School of Medicine

6:30– 8:00 Reception for Conference Participants, Hotel Pfister—Tickets available at registration desks and at reception . . . $5.00 per person

8:00 Milwaukee County Intern-Resident Association, Hotel Pfister

SATURDAY, NOVEMBER 13

Diagnosis in Special Circumstances

Presiding: *L. W. Worman, M.D.*

9:30–10:00 The Patient Under Anesthesia, *Ernest O. Henschel, M.D.*, Associate Professor of Anesthesiology, Department of Anesthesiology, Marquette University School of Medicine

10:00–10:15 The Postoperative Patient, *Larry C. Carey, M.D.*

10:15–10:30 The Patient Who Gets Sick in the Hospital, *Joseph A. Manago, M.D.*, Instructor in Surgery, Marquette University School of Medicine

10:30–11:00 Diagnosis in the Patient with Known Cancer Treated or Untreated, *John D. Hurley, M.D.*, Associate Clinical Professor of Surgery, Marquette University School of Medicine

ANNUAL DEARHOLT DAY LECTURES • NOVEMBER 10 • MILWAUKEE AND MADISON

Dr. Stanford Wessler, professor of medicine at Washington University School of Medicine and physician-in-chief of Jewish Hospital of St. Louis, will be guest speaker at the annual Dearholt Day lectures November 10 in Milwaukee and Madison.

Doctor Wessler's address is entitled "To Experimental and Clinical Aspects." It will Clot Or Not To Clot—Pulmonary Embolism, be delivered at 12:30 p.m. in Coffey Auditorium at Milwaukee County General Hospital and at 4 p.m. in the auditorium of Service Memorial Institute, University of Wisconsin, Madison.

The scientist became head of the anticoagulant clinic of Beth Israel Hospital, Boston, in 1960, and director of clinical research at the hospital in 1961. He is the former director of a program project grant on thrombosis and atherosclerosis at Harvard and Beth Israel.

The Dearholt Day lectures are sponsored cooperatively by the Marquette University School of Medicine, University of Wisconsin Medical School, Wisconsin Anti-Tuberculosis Association and the Wisconsin Thoracic Society. The series began in 1940.

1965–1966 TELEPHONE CONFERENCES

(Details on page 62)

Registration Form

Hospital Where You Will Attend Conferences

Last Name First Middle County of Residence

Mailing Address City Zip Code

—Solo Practice
—Group Practice
—Years in Practice

Type of Practice
—Unlimited
—Limited to:
Specify
—Intern
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Date

Signature

Please return, with $50.00 registration fee, to: Telephone Conferences, Wisconsin Center, 702 Langdon Street, Madison, Wisconsin 53706. Make checks payable to University of Wisconsin Extension.

1966 ANNUAL MEETING • La CROSSE

CELEBRATING THE 125TH ANNIVERSARY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Preliminary Announcement

Plans listed below will indicate the basic portions of the Annual Meeting, May 9–10–11–12, 1966.

MONDAY, MAY 9

House of Delegates: Meet for lunch and afternoon session.

Exhibits: Scientific, technical, art show, and photography contest, installed prior to 5 p.m.

Special Feature: Evening of refreshments and entertainment by the Heileman Brewery of La Crosse. This is a special social event for all members and wives, as well as exhibitors.

TUESDAY, MAY 10

Scientific Program: Special morning program on "Renal Disease." Afternoon programs on Obstetrics–Pediatrics, Internal Medicine, and Pathology.

House of Delegates: Late afternoon session.

Special Feature: Large public meeting in the evening, with nationally-known speaker. Also, informal entertainment available for all visiting MDs and wives.

WEDNESDAY, MAY 11

Scientific Program: Special morning program on "Space Medicine." Afternoon programs on "Intensive Care in Cardiorespiratory Diseases" (with Wisconsin Heart Association as joint sponsor), and EENT.

Annual Dinner: An evening program which will be pure fun and sociability. Special entertainment being planned by La Crosse County Medical Society to make this a delightful evening for all who attend.

THURSDAY, MAY 12

Scientific Program: Morning program on "Newer Drugs and Drug Reactions." Afternoon programs on Surgery and Radiology.

AUXILIARY EVENTS

Mrs. F. H. Wolf, president of the Woman's Auxiliary to the State Medical Society, has planned two outstanding luncheon events on Wednesday and Thursday, May 11–12. Short business sessions on Wednesday and Thursday, planned so as not to interfere with social events being planned.

SPECIAL EVENTS

Art Show, Photography Contest, Local Stage Shows, and other entertainment features being planned.

PROGRAM DETAILS AND HOUSING FORMS IN JANUARY–MARCH ISSUES

La Crosse County Coordinating Committee 1966 Annual Meeting

General Chairman

Arrangements: Robert L. Gilbert, MD, La Crosse

Subcommittees

Administration and Publicity: Robert L. Gilbert, MD and Robert B. Rasmus, MD, La Crosse, co-chairmen; Wm. A. Himmelsbach, MD, J. F. Lifsrud, MD, and Thorolf E. Gundersen, MD, La Crosse.

Extracurricular Activities: George B. Murphy, Jr., MD and Mark T. O'Meara, MD, La Crosse, co-chairmen; Allen G. Brailey, MD, Robert E. Whiteway, MD, Paul W. Phillips, MD, and John W. Hayden, MD, La Crosse.

Housing: John J. Sevenants, MD and Frederick H. Wolf, MD, La Crosse, co-chairmen; and Gregory J. Egan, Jr., MD, La Crosse.

Ladies Activities: Mrs. Frederick H. Wolf, president, Woman's Auxiliary to SMS; and Mrs. Ubaldo Alvarez, president, La Crosse County Woman's Auxiliary, La Crosse.

Meeting Sites: Sigurd B. Gundersen, Jr., MD, La Crosse, and David L. Morris, MD, West Salem, co-chairmen; David H. Corser, MD, La Crosse, Karl P. Ruppenthal, MD, Bangor, and Fred Skemp, MD, La Crosse.

Scientific Coordinating: Sigurd E. Sivertson, MD, La Crosse, chairman; Sigurd B. Gundersen, Jr., MD, La Crosse, David L. Morris, MD, West Salem, David H. Corser, MD, Robert A. Pribek, MD and Joseph B. Durst MD, La Crosse.

Transportation: Archie G. Britt, MD, La Crosse, chairman; and George P. Gersch, MD, West Salem, Albert A. Fisher, MD and George B. Ellenz, MD, La Crosse.

HOUSING FOR THE 1966 ANNUAL MEETING

A special Housing Bureau for the 1966 Annual Meeting has been set up by the La Crosse County Medical Society, and all members and exhibitors will be notified concerning rooms after Jan. 1, 1966. A complete listing of facilities will be given, and the proper form to fill out for the reservation of sleeping rooms.

DO NOT SEND A REQUEST FOR ROOMS TO EITHER THE HOUSING BUREAU OR THE STATE MEDICAL SOCIETY BEFORE RECEIVING PROPER NOTIFICATION OF FACILITIES AND FORMS TO USE. NO RESERVATIONS WILL BE HONORED PRIOR TO THE OFFICIAL NOTIFICATION.

ROBERT L. GILBERT, M.D., La Crosse
General Chairman: 1966 Annual Meeting

OFFICIAL CALL
for Scientific Exhibits

1966 ANNUAL MEETING, LA CROSSE, MAY 9–10–11–12

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1966 Annual Meeting. The exhibits will be located in **Sawyer Auditorium, La Crosse.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1966 meeting are requested to file an application before Jan. 1, 1966, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Assignments made as exhibits approved by Commission on Scientific Medicine.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Brede Inc, Minneapolis on form to be furnished all exhibits scheduled)

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 4′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: JAN. 1, 1966.**
Address your communications to:

E. S. Gordon, M.D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison Wis. 53701

USE FORM ON OPPOSITE PAGE→

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBIT

1966 Annual Meeting — La Crosse — May 9–10–11–12

★

Fill out the following information and mail to:

E. S. GORDON, M. D., *Director of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. **Feet Required:** _____ **(In figuring feet required, remember the space is only 4′ deep, so your exhibit must be flush against the back wall.)**
   (Space is scarce so ***do not request more than is necessary****)*

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

DEADLINE: All applications must be filed by Jan. 1, 1966. Assignments made by Feb. 1.

the wisconsin medical journal

VOLUME 64/NUMBER 10 OCTOBER 1965

CLINICAL STUDY

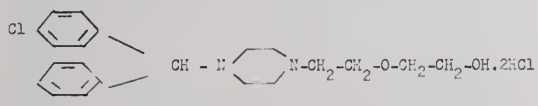
Use of Hydroxyzine in Management of Labor

By WILLIAM L. SEMLER, M. D., Milwaukee, Wisconsin

■ THROUGH THE YEARS obstetric analgesia has been subjected to many changes. All of these changes have been aimed at making labor and delivery more comfortable, mentally and physically, for the pregnant woman without jeopardizing the unborn infant. With these concepts in mind hydroxyzine (Vistaril) was employed in this study.

Adriani[1] and Cottrell[2] have effectively used hydroxyzine to enhance narcotics for surgical preanesthetic medication. Mulla,[3] Siduranza and Tisdall[4] have shown hydroxyzine to be efficacious in reducing apprehension and fear in early labor, and Benson and Benson[5] proved hydroxyzine to have no adverse effect upon Apgar[6] ratings.

Hydroxyzine hydrochloride is a derivative of diphenylmethane and can be classified as either an ataractic or as an antihistaminic agent.[7] It is characterized chemically by a piperazine nucleus with a terminal aliphatic ether chain in this structural formula:



Materials and Methods. This drug has been used by the author on a total of 1,255 patients, near or at term, both private and clinic, under his direct supervision over the past four years.* Cesarean section patients and deliveries prior to the 37th week were not included in this series.

The patients ranged in age from 15 to 45 years and consisted of 350 primigravida patients and 905 multigravida patients (Table 1).

Upon admission to the hospital, the patients received an injection of either 50 or 100 mg of hydroxyzine hydrochloride, with or without 50 mg of meperidine hydrochloride (Demerol), depending upon patient requirement for sedation. Following this initial dosage, 50 mg of hydroxyzine and 50 mg of meperidine were given at two-to-four-hour intervals, varying with individual patient sedation requirements. Some patients never required any meperidine at all prior to delivery, and the "50/50" medication was given from one to three times to the remaining patients. In many instances this "50/50" medication was prescribed within one hour of delivery if required.

TABLE 1—*Total Number of Patients Included in This Study, According to Age Group and Number of Deliveries Per Patient*

Parity	Age						Total
	15-19	20-24	25-29	30-34	35-39	Over 40	
1	80	199	51	16	4	0	350
2	21	170	99	42	5	4	341
3	3	91	108	44	6	2	254
4	1	15	78	46	6	1	147
5	0	9	41	24	8	0	82
6	0	1	21	16	7	2	47
7 or more	0	0	9	15	8	2	34
Total	105	485	407	203	44	11	1255

*The private patients were delivered at both St. Joseph's Hospital and St. Michael's Hospital, Milwaukee. The Clinic patients were delivered at St. Michael's Hospital where Doctor Semler was Director of the Obstetric and Gynecologic Clinic from 1961 to 1963.

TABLE 2—*Type of Anesthesia Used*

General anesthesia	565
Pudendal block	378
Local infiltration	134
Saddle block	84
None	94
Total	1255

There were 565 patients delivered under general anesthesia, utilizing cyclopropane, nitrous oxide, and oxygen. A majority of these patients was given 100 mg of hydroxyzine on admission. The anti-secretory effect of this drug was sufficient for general anesthesia if given within two hours of delivery time; otherwise, 0.3 mg of atropine was administered intravenously prior to delivery. The remaining 690 patients were delivered by pudendal block, local infiltration, saddle block, or without any anesthesia at all (Table 2).

There were 938 patients who delivered spontaneously, 268 patients were delivered by low forceps, 21 patients were delivered by mid-forceps for rotation and 28 patients presented a breech for delivery.

Results. The most striking and characteristic patient response, especially from the nursing standpoint, was the overall improvement in patient cooperation; 92% of the patients showed good to excellent cooperation which was in direct proportion to their analgesic effect.

The patients were calmed without mental depression, thus were more alert and eager to be a part of their delivery.

Apprehensions and anxieties were effectively reduced without interfering with uterine contractions.

Labor times were 9.12 hours for primigravidas and 6.09 hours for multigravidas as compared to times listed in obstetric textbooks ranging from 10.59 to 16.57 hours for primigravidas and 8.12 to 10.91 hours for multigravidas.[8,9,10]

There was no instance of hypotension noted, nor any other undesirable general side effect in any patient or infant. Four patients experienced a transitory local inflammatory reaction around the injection site.

The newborn infants were rated according to the Apgar[6] scale; 95% of the ratings were 8.0 or better and the overall rating was 9.01 for all infants delivered in this series.

The anti-secretory effect of the drug was found to be adequate if the drug was given within two hours of delivery time.

Comment. Hydroxyzine hydrochloride proved to be a most desirable adjunct to narcotic medication for prepartum use. It augmented meperidine's desirable effects, was found to be free from side effects, and because of meperidine potentiation it was necessary to use lesser amounts of meperidine, resulting in a diminution of the undesirable qualities of the narcotic preparation.

Summary. Hydroxyzine hydrochloride (Vistaril) was employed as a prepartum medication in conjunction with meperidine hydrochloride (Demerol) for analgesia in 1,255 patients at or near term, and it proved to be safe and useful in the management of labor. Patient cooperation was excellent, examination was made easier throughout labor, and delivery proved to be more facile. The patients remained calm, but they were alert and eager to participate in their delivery. Labor times were shortened, 9.12 hours for primigravidas and 6.08 hours for multigravidas. There was no evidence of hypotension or other undesirable side effects. The average Apgar rating was 9.01 for all deliveries.

8430 West Capitol Drive (53222).

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Plummer-Vinson Syndrome with Celiac Sprue

By GEORGE L. RIVER, M. D. and ALAN R. ARONSON, M. D., Lackland Air Force Base, Texas

■ THE PLUMMER–VINSON syndrome, known as "sideropenic dysphagia" in the Scandinavian countries and "Paterson–Brown Kelly syndrome" in England, is characterized by severe iron deficiency of obscure etiology in middle-aged, neurotic women with dysphagia and objective changes in the mucosa of the pharynx and esophagus. Classically, an esophageal "web" is present. Plummer, in 1908[1] and 1912,[2] described certain aspects of the syndrome, later amplified in the same group of patients by Vinson in 1922.[3] Paterson[4] and Brown Kelly,[5] in papers presented to the Royal Society of Medicine in May 1919, were the first to describe the complete syndrome.

Spasm, hysteria, streptococcal glossitis, riboflavin deficiency, tertiary lues, and inflammatory involvement of the nerve supply of the pharynx and esophagus have been proposed as etiologic factors. These have been rejected as untenable. The current concept[6-9] is that Plummer–Vinson syndrome is an unusual manifestation of severe and prolonged iron deficiency. Case reports from the United States during the last 20 years are rare, perhaps because of the addition of iron to commercially prepared bread.[8,9] The relationship of the Plummer–Vinson syndrome to postcricoid carcinoma has been debated in the past[10,11] but seems to be well established now.[8,9,12]

Review of the reported series of Plummer–Vinson syndrome allows two interesting observations: (1) There is no apparent reason for the iron deficiency in 70 to 90 per cent of the cases, and (2) iron absorption and/or utilization studies have not been done, even in those cases failing to respond to oral iron therapy. We are unaware of any previous report of the association of Plummer–Vinson syndrome and celiac sprue.

CASE REPORT. A 37-year-old American woman of Portuguese ancestry was referred to the hospital in January 1961 for evaluation of anemia and duodenal ulcer. She had enjoyed good health until 1953, when she first noted "indigestion." Highly seasoned foods and fasting produced burning epigastric pain, which was relieved by milk and various proprietary antacids. X-ray studies made in 1955 were interpreted as showing an ulcer. A regimen of a bland diet and oral iron (for "anemia") resulted in amelioration of symptoms. No abnormal blood loss was detected then or later.

From 1956 to 1960, the patient experienced intermittent epigastric distress, occurring mostly in the spring and fall. Graying of the hair, first noted at age 17, progressed remarkably. During the spring of 1960, indigestion and epigastric pain became more severe. Previously effective remedies gave little relief. Paresthesias of the hands developed and continued to be a problem. During most of July and August, 1960 the patient had watery, malodorous diarrhea associated with cramping abdominal pain. On two or three occasions, stools were quite bulky and floated. As the diarrhea subsided, soreness of the tongue and dysphagia developed, and the patient lost 10 lb in the next three months. These symptoms became more severe during December 1960. An aversion to food resulted in an additional 30-lb weight loss. Her husband stated that she dreaded eating and had lost all interest in herself and her surroundings.

Physical Examination and Laboratory Data. The patient appeared cadaverous on admission to the hospital. She was 69½ in tall and weighed 100 lb. Her cheeks and eyes were deeply sunken. Her lips were small and pursed, and her tongue was pale and ridged, with atrophy of the papillae at the edges. Pallor, poor tissue turgor, and dry skin were present. Her fingernails had the consistency of bees' wax, but there was no koilonychia. Abdominal organs were not enlarged. She was apathetic, depressed, and resigned.

The initial hematologic evaluation showed a red blood cell count of 4,350,000, hemoglobin level 8.0 gm/100 ml, and hematocrit reading 30%. The reticulocyte count was 0.5%. Marked hypochromia and microcytosis, in addition to a moderate number

From the Department of Medicine, Wilford Hall USAF Hospital Aerospace Medical Division (AFSC), Lackland Air Force Base, Texas.

This paper represents the personal viewpoint of the authors and is not to be construed as a statement of official Air Force policy.

Doctor River was formerly with the Hematology Section, Wilford Hall USAF. Current address: Marshfield Clinic, Marshfield, Wis.

Doctor Aronson was formerly chief, gastroenterology Section, Wilford Hall USAF Hospital. Current address: Evanston, Ill.

Fig. 1—Barium swallow utilizing the technique of Waldenstrom.[13] The anterior esophageal web is readily visualized.

of target cells, were seen on the blood film. Bone marrow examination revealed moderate normoblastic hyperplasia. Hemoglobin electrophoresis was normal and fetal hemoglobin was less than 1%. The serum iron was 27 and the serum iron-binding capacity was 425 mcg/100 ml. Pertinent hematologic data are given in Table 1.

Barium studies showed a deformed duodenal bulb without evidence of a crater. In addition, a small functionally insignificant esophageal "web" was present (Fig 1). This was seen with an esophagoscope immediately below the level of the cricoid cartilage anteriorly. Small-bowel x-ray films demonstrated some abnormal clumping of barium, but were not diagnostic.

Results of the following studies were either negative or within normal limits: serologic test for syphilis, chest x-ray film, multiple stool examinations for blood, ova, and parasites; throat culture, prothrombin time, serum proteins (chemical and electrophoretic), serum bilirubin, lupus erythematosus cell preparations, febrile agglutinins, serum and sweat electrolytes, urinary excretion of 5-hydroxyindole-acetic acid, 17-hydroxycorticoids and 17-ketosteroids, sulfobromophthalein retention, serum transaminases, serum calcium and phosphorus, lumbar puncture, pulmonary function studies, fecal trypsin activity, and duodenal fluid volume and bicarbonate concentration following secretin stimulation.

Hospital Course. The patient improved significantly with oral anticholinergic agents, multiple

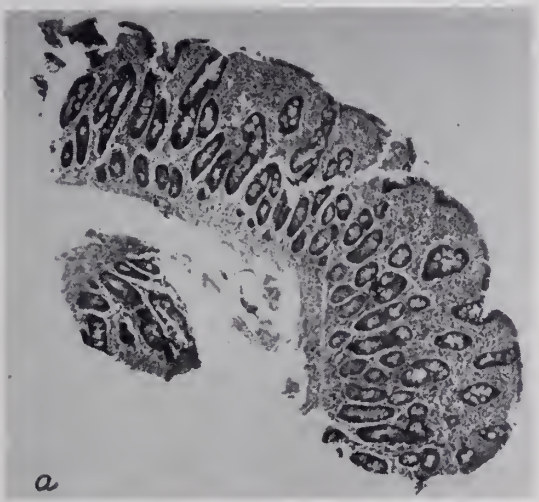
TABLE 1—*Hematologic Data*

Date	Hgb. (gm 100 ml)	Hct.	RBC ($x10^6$)	% Retic.	Serum Iron (mcg 100 ml)	Iron-Binding Capacity (mcg 100 ml)	Comments
1-9-61	8.0	30	4.35	0.5			Marked hypochromia, microcytosis, moderate number of target cells
1-13-61	7.0	30		0.6	27	448	
1-27-61	9.2	32			23	379	
2-6-61	8.5	31	4.96				After 4 weeks of oral iron
2-28-61	7.6	32			23		2 hours after oral dose of 400 mg elemental iron; gluten-free regimen started
3-21-61	11.1	40		0.3	138		After 2 units of blood
5-22-61	11.8	40		0.5	41		10 ml iron-dextran intramuscularly
9-26-61	14.8		4.75	0.3	118	268	RBC morphology normal
10-15-61					100		Fasting
10-15-61					173		2 hours after oral dose of 400 mg elemental iron

TABLE 2—*Studies of Small-Bowel Absorption*

Study	Before Therapy	After Therapy (Gluten-free Regimen)
Serum Vitamin A Level (IU%)	56.9	461.0
Serum Beta Carotene (mcg %)	5.3	77.4
Serum Phospholipids (mg %)	150	354
Total Serum Lipids (mg %)	611	694
Cholesterol (Total) (mg %)	150	172
Radioactive Triolein Uptake	Normal	Normal
Schilling Test (Base)	17.5	
Oral Glucose Tolerance Test	'Flat' curve	
D-xylose Absorption Test		
Blood Level (Peak) (mcg %)	12.0	30.0
Urinary Excretion (gm 5 hr)	1.9	4.1
% Fecal Excretion of Oral Dose of Fe^{59}	100	
Fecal Fat Studies		
% Fat Content	25–50 (Multiple Determinations)	10 (Single Determination)
gm Fat 24 hr	20–100 (Multiple Determinations)	15 (Single Determination)

small feedings of a liquid diet, and adequate dosage of analgesics. Oral iron therapy was begun with 2 gm ferrous sulfate daily. However, after three weeks of treatment, the hemoglobin level, reticulocyte count, and serum iron had not changed. This lack of response led to the small-bowel function studies listed in Table 2. A small-bowel biopsy (Fig 2) was obtained with the Crosby capsule. A review of these slides indicated a diagnosis of celiac sprue. A gluten-free regimen was instituted and two units of packed red blood cells were given (intramuscular iron was then unavailable and intravenous iron was



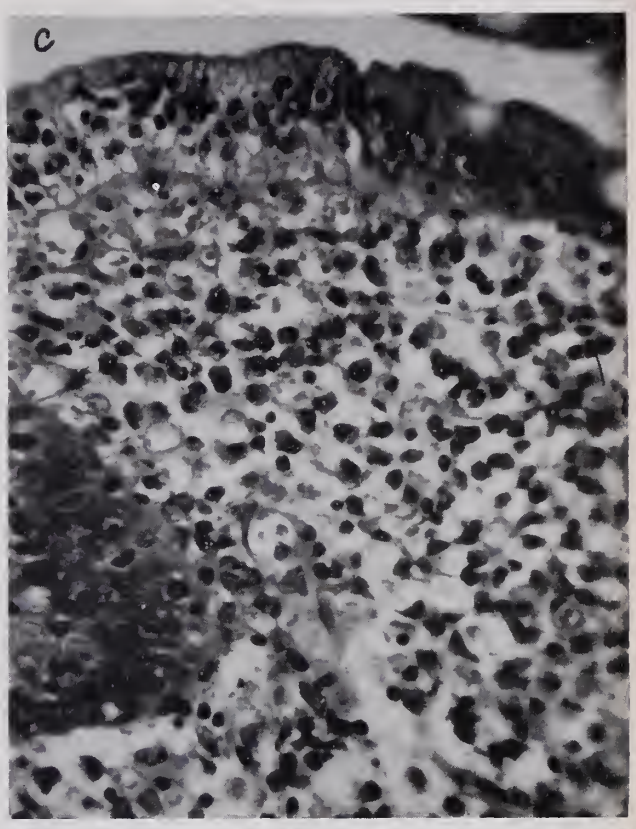


Fig. 2—Originol small-bowel biopsy (jejunum). Marked reduction in the epithelial surfoce with flottening, vacuolization, nuclear migrotion from the usuol bosal location, and frequent pyknotic nuclei ore noted. The intense infiltration is seen to consist of plosmo cells with occosionol lymphocytes and eosinophils. (o) 35 X (b) 100 X (c) 430 X.

not tolerated). Ten ml of iron-dextran complex were administered intramuscularly shortly before her discharge after a two-month hospitalization.

Follow-up. The patient was re-evaluated in October 1961, after approximately eight months of therapy. She had gained a total of 42 lb and felt well except for occasional headaches. Her appetite was good, and she was faithfully observing a gluten-free regimen. Hematologic data recorded at this time were normal (Table 1). The patient was able to absorb oral iron as demonstrated by a sharp rise in serum iron following an oral load of ferrous sulfate. A second small-bowel biopsy was technically unsatisfactory, but changes similar in magnitude to those of the first biopsy were observed. Small-bowel x-ray films showed segmentation and flocculation of barium consistent with sprue. Results of small-bowel function studies are summarized in Table 2.

The patient was discharged on oral iron therapy and a gluten-free regimen. In February 1962, she was feeling well and had gained an additional 8 lb.

TABLE 3—*Plummer–Vinson Syndrome, Typical Clinical Features*

Female, middle aged
Gray hair
Wrinkling of facial skin
Thin, stiff lips with perleche
Edentia
Tongue depapillated and inflamed
Koilonychia
Splenomegaly
Dysphagia
Paresthesias
Hypochromic, microcytic anemia
Achlorhydria
Esophageal web or band
Normoblastic bone marrow hyperplasia
Mental aberrations
Chronic inflammatory changes in mouth, pharynx, and upper esophagus

Discussion. That Plummer–Vinson syndrome is a nosologic entity distinct from simple iron deficiency has been questioned.[6,7] The clinical features, summarized in Table 3, provide a logical basis for the continued separation of those cases manifesting profound epithelial changes with prolonged, severe iron deficiency. The finding of generalized squamous dysplasia should stimulate a careful search for the cause of the iron deficiency. Its association with postcricoid carcinoma makes necessary prolonged intermittent iron therapy and follow-up examinations.

Most, if not all, of the patients with malabsorption syndromes have defective iron absorption.[14] The majority of patients with celiac sprue (gluten-enteropathy), if they are anemic, show hypochromia and microcytosis on their blood films.[15,16] While macrocytic anemia is characteristic of tropical sprue, defective iron absorption is present and folic acid therapy results frequently in the emergence of an iron-deficiency anemia.[17] Witts, in 1931,[18] noted the similarity in symptomatology of Plummer–Vinson syndrome and sprue syndrome. Hawkins, in 1950,[19] presented 6 cases of steatorrhea with severe iron deficiency; of these, 2 had dysphagia. The association of ulcerative colitis and Plummer–Vinson syndrome has been reported.[20] A recent, excellent presentation of the Paterson–Brown Kelly syndrome and review of the world literature recorded data in 94 cases.[8,9] In this series, 14 per cent failed to respond to oral iron therapy, but no mention was made of iron absorption or small-bowel function studies.

It is apparent that malabsorption of iron is an important cause of iron deficiency and, as such, of the Plummer–Vinson syndrome. We believe that many of the patients with Plummer–Vinson syndrome reported previously as refractory to properly administered oral iron may have had celiac sprue with malabsorption of iron.

The pathologic changes in nontropical sprue are maximal in the proximal jejunum.[21] Experimental evidence indicates that iron absorption (active transport) is limited essentially to the same area.[22] The presence of excess fat in the gastrointestinal tract does not inhibit iron absorption.[14] The use of a high-protein, low-fat regimen in celiac sprue is not attended by any increase in iron absorption, even in the presence of marked iron deficiency.[23] Badenoch and Callender[23] have shown that patients with celiac sprue increase their ability to absorb iron following the introduction of a gluten-free regimen; a more striking increase in iron absorption occurs during steroid therapy.

Measurements of gastrointestinal absorption of iron based on the incorporation of Fe^{59} into hemoglobin have been criticized justly as introducing a number of variables. In this study the method described by Bonnet[24] was used. A total oral iron dose of 50 mcg was given with ascorbic acid. All stools were collected until the daily radioactivity of the stools was less than 1 per cent of the administered dose. Normally between 34 and 75 per cent of the radioiron is absorbed.

The biochemical nature of the generalized squamous dysplasia, which is characteristic of Plummer–Vinson syndrome, is not known. Perhaps the iron enzyme systems necessary for the maintenance of epithelial integrity are particularly vulnerable to prolonged iron deficiency in patients with Plummer–Vinson syndrome.

Summary. The patient described here presented with the classic manifestations of severe iron deficiency but failed to respond to oral iron. Appropriate small-bowel function studies, including jejunal biopsy and newer methods of measuring radioiron absorption, demonstrated malabsorption of iron and established the diagnosis of sprue. Inasmuch as defective iron absorption is characteristic of malabsorption states, a thorough investigation of small-bowel function is mandatory in any patient with iron deficiency who does not respond to properly administered oral iron.

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CASE REPORT

Systemic Lupus Erythematosus Causing Heart Block

By JOHN H. BECKER, M. D., Watertown, Wisconsin

■ THE HEART was one of the first organs to show pathologic evidence of the developing spectrum of systemic lupus erythematosus (SLE). The original description of lupus endocarditis by Libman and Sacks[1] was a major step in the formulation of the extensive systemic involvement of SLE. Prior to the development of the lupus erythematosus preparation (LE prep), a large part of the pathologic and clinical literature was devoted to the heart. Cardiac involvement is frequent in autopsied cases of SLE.[2] In a review article, the myocardium was involved in 35%, the endocardium in 55%, and the pericardium in 70%.[3]

Atrioventricular and ventricular conduction defects are uncommonly reported in SLE. Therefore, a woman with SLE who had both, and the former to a rather remarkable degree, seems to be of interest.

CASE REPORT. A 42-year-old white woman entered the hospital in August 1963 following an episode of "passing out" at home. She had a diagnosis of SLE for six years prior to this time. When first seen in April 1957, her main complaint was of pain in the left side of the chest. She stated that the pain had been present for approximately six months, and that its degree had been variable. Associated with her chest complaint was increasing exertion dyspnea and two-pillow nocturnal dyspnea. She also had palpitation. She noted weakness and arthralgia involving the shoulders, left elbow, and middle joints of the fingers. There was a moderate amount of urinary frequency and nocturia.

In 1945 she had been seen by a dermatologist who made a diagnosis of seborrheic dermatitis of the face and scalp and an acne oleosa of the face with the additional impression that "this may be lupus erythematosus."

On physical examination, the patient appeared to be somewhat pale and chronically ill but did not appear to be in any acute distress. There was a slight suggestion of a butterfly type of rash on her face. A rare rale was noted posteriorly after coughing. The heart was enlarged to percussion and a moderately loud, systolic, apical murmur was present.

Routine laboratory studies showed a normal urine, mild anemia, and leukopenia. Five blood cultures were negative. The sedimentation rate was slightly elevated. The blood urea nitrogen and serum albumin were normal. Serum globulin was increased to 4.8 mg/100 ml. Two LE preps were positive. An electrocardiogram (ECG) (Fig 1) was consistent with nonspecific myocardial damage, and a chest x-ray film showed minimal left ventricular enlargement.

Prior to treatment the patient was in moderate distress and had a somewhat elevated temperature. Treatment was started with 15 mg of prednisolone daily and she made a satisfactory response. An episode of pyelonephritis occurred one month after prednisolone was started, but she responded well to antibiotic therapy.

In December 1957 she developed signs and symptoms of pulmonary congestion. A chest x-ray film at that time showed in addition to left ventricular enlargement, minimal pulmonary vascular congestion and small pleural effusions. She required digitalization and an occasional mercurial diuretic for a period of three months. After that no therapy was necessary for the heart until her final admission.

The patient had received prednisolone in gradually decreasing dosage from April 1957 until March 1958. Chloroquine was started in March 1958 and this was continued until December 1961. The initial dose was 250 mg three times a day and the maintenance dose was 250 mg two times a day. On the whole, her clinical course was satisfactory until February 1961 at which time she complained of inability to see and was quite nervous. At that time, a physical examination and laboratory studies were normal. The LE prep was negative and the serum globulin was not elevated. After that she was treated with 10 mg of chlordiazepoxide two times daily, and her emotional difficulty seemed to decrease. An ophthalmologic consultation revealed diminished visual fields peripherally, and a diagnosis of chloroquine retinitis was made. This remained constant until her death.

In April 1963 she was hospitalized with what appeared to be a mild recurrence of SLE. Physical examination was unchanged. Again the LE preps were negative and other laboratory studies were unremarkable. The ECG (Fig 2) showed left bundle branch block for the first time. She was treated with 20 mg of prednisolone daily, made an uneventful clinical recovery, and was discharged in five days. As an outpatient she seemed to be having a rela-

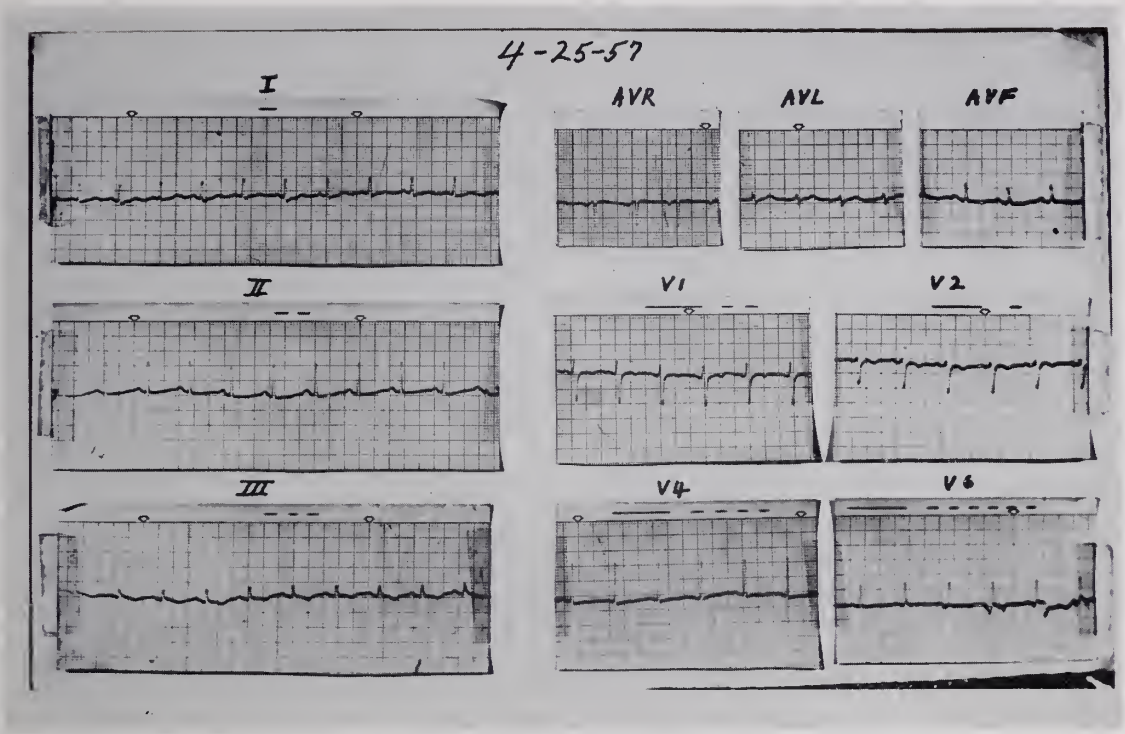

Fig. 1—Electrocardiogram taken at anset af the present illness.

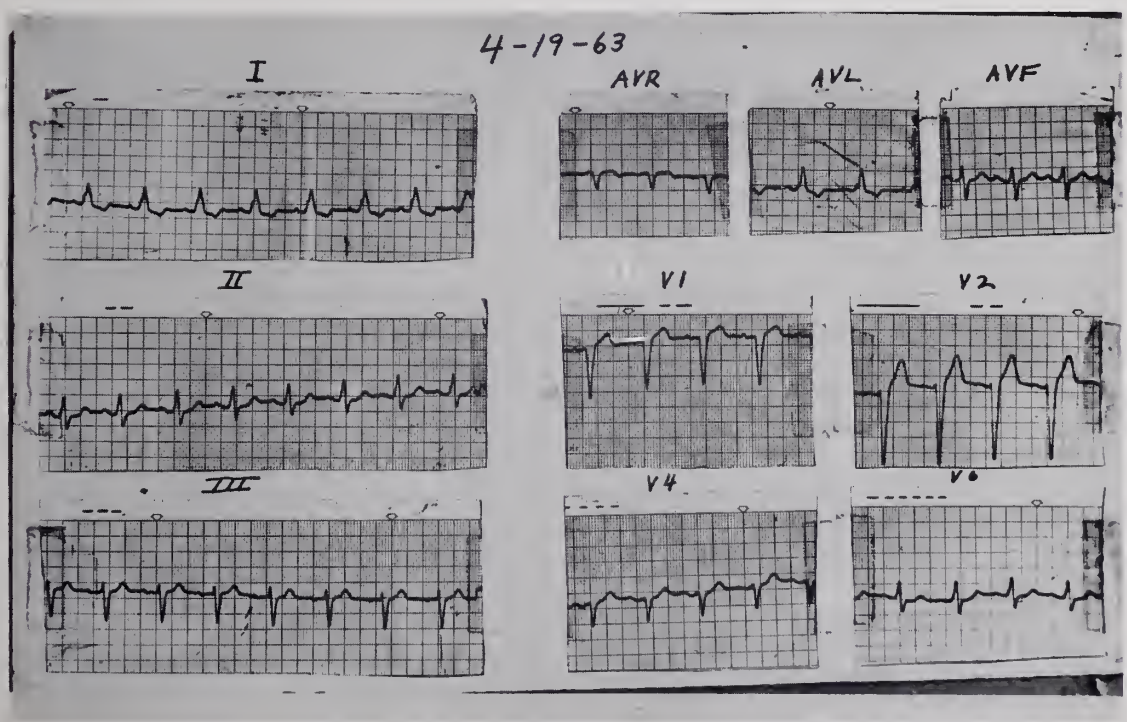

Fig. 2—Electrocardiagram showing left bundle branch black.

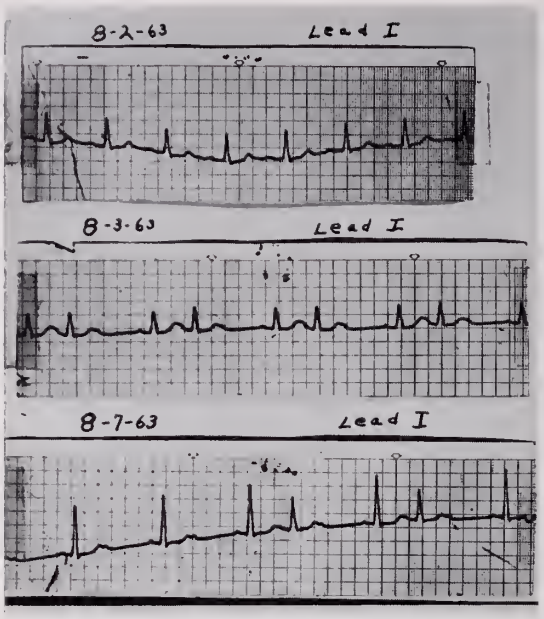

Fig. 3—Series of electrocardiograms taken during patient's hospitalization and showing various degrees of atrioventricular block.

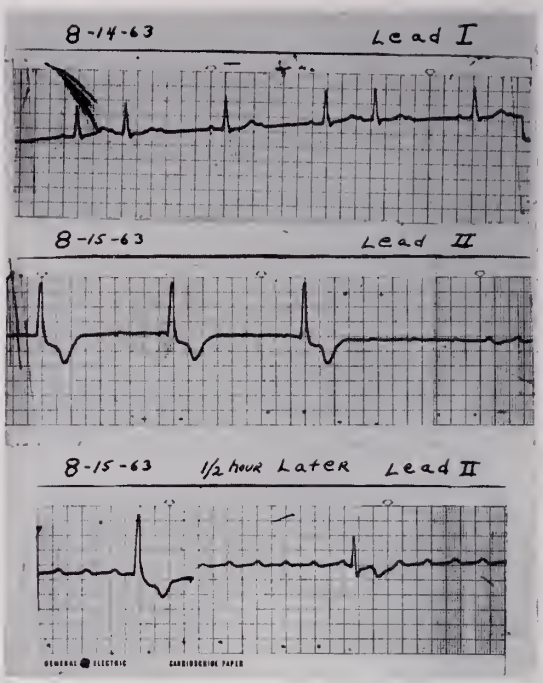

Fig. 4—Electrocardiogram taken on the day prior to death and two tracings during her final episode.

tively benign course and the prednisolone was gradually decreased to 7.5 mg daily.

In August 1963 she "passed out and turned blue" while watching television. Because she lived on a farm 10 miles from the hospital, she was not admitted to the hospital until 25 minutes had passed. It was then noted on auscultation that her cardiac rhythm was irregular. By the time an ECG (Fig 3) was taken, it showed first degree atrioventricular block and continued to show complete left bundle branch block. Except for the cardiac rhythm the physical examination and laboratory studies were unaltered.

She was placed on dexamethasone, 6 mg daily, and isoproterenol, 10 mg sublingually every two hours. The next day the ECG showed an atrioventricular rhythm which demonstrated first and second degree heart block. This seemed to be relatively stable during most of this hospitalization. Despite the persistence of the atrioventricular block no further episodes of syncope occurred.

The clinical course was good until the afternoon of her death when the nurse noticed that the patient was unconscious, apneic, cyanotic, and had a slow heart rate. Artificial respiration was instituted by the nurse with apparent spontaneous resumption of respiration and consciousness. When counted a few minutes later the heart rate was observed to vary between 6 and 12 (Fig 4).

Levarterenol bitartrate (norepinephrine), 8 ml in 1,000 ml of distilled water, was given intravenously. The blood pressure was 70/0 mm Hg and did not rise. Epinephrine, 1/1000, was given intravenously in 0.2 mg and 0.4 mg dosages with no effect. Finally 150 ml of six molar lactate were given. However, the heart rate was unchanged and the patient died.

A postmortal examination was performed 15 hours after death. Grossly the principal findings were confined to the heart which weighed 400 gm. The endocardial surfaces were normal. The coronary arteries were normal and the myocardium appeared normal grossly. All other organs were normal with the exception of the pleural cavities which were completely obliterated by fibrous connective tissue adhesions.

Microscopic examination showed all organs to be normal except for the myocardium. In some of the sections taken from the region of the distribution of the conduction system there was extensive loosening of the fibrous tissue between the muscle bundles so that a loose areolar network was almost formed (Fig 5). There was marked degeneration of the muscular fibers with replacement by fatty tissue. A marked degeneration of some of the muscle fibers was noted with only the sarcolemma remaining. Many of the muscle fibers showed enlarged hyperchromatic nuclei and some areas of fibrinoid necrosis were noted in the myocardium just beneath the endocardium. Focal areas of acute inflammatory infiltrate (Fig 6), one of which was very pronounced showed many polymorphonuclear leukocytes, a few plasma cells and lymphocytes, were noted just beneath the endocardium in the myocardium. These were surrounding blood vessels. Focal areas of inflammatory infiltrate were noted in the endocardium about the papillary muscles. These consisted of lymphocytes and plasma cells. Focal areas of in-

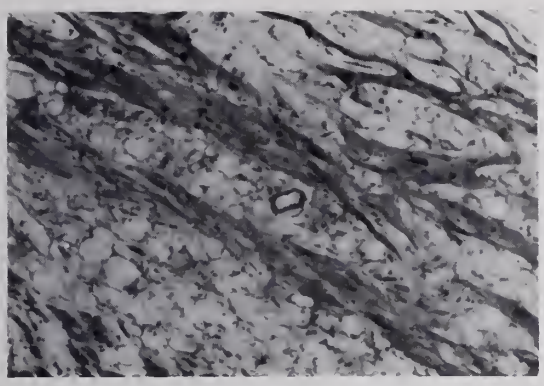

Fig. 5—Section of the myocardium.

Fig. 6—Inflammatory reaction in a portion of the myocardium.

filtration and polymorphonuclear leukocytes were noted scattered here and there throughout the muscle fibers, and were quite prominent in one of the sections. The muscle bundles were separated by edema, and collections of polymorphonuclear leukocytes were noted. The blood vessels showed only occasional areas of fibrinoid necrosis. These were prominent with marked diminution of the lumen of the vessel and marked thickening of the walls with collections of plasma cells, lymphocytes and occasional polymorphonuclear leukocytes. These were not very prevalent, however. The majority of the vessels showed no particular abnormalities.

Comment. Knowing that the diagnosis in the case presented was SLE and thinking of the similarity to rheumatic fever as "collagen" disease, the author inferred that cardiac conduction defects would be relatively common. Again, we would expect that with myocarditis being present in 35% of the patients who have SLE that conduction defects would be frequent. A survey of the literature did not indicate that this was the case.

In several series, atrioventricular conduction defects were uncommon except for rare reports of first degree block.[3–7] Left bundle branch block was not noted. Two cases were reported with first degree heart block and in both of these instances the attending physicians initially thought the diagnosis was rheumatic fever. Post mortem showed SLE.[8,9] There have been other case reports in which the PR interval was increased and in one case a 13-year-old Negro girl with pericardial effusion had Wenckebach phenomenon.[10]

In a review article of complete heart block in which 278 cases were reviewed, none were diagnosed as SLE.[11] And in another review article on Adams–Stokes syndrome none of the cases were found to have SLE.[12] Parenthetically the initial episode of the final admission and the episode which precipitated the patient's demise were Adams–Stokes attacks. Since their etiology is not uniform, it was felt best to emphasize the cardiac conduction defect actually demonstrated.

It is evident from the pathologic findings of the myocardium that the severe and relentless myocarditis caused the conduction defects in this patient. Despite what is commonly considered to be adequate anti-inflammatory therapy with adrenal cortical steroids, the inflammation reaction was too severe to be altered.

Recently chloroquine has been reported to cause muscular weakness and in one instance an intraventricular conduction delay.[13] However, in the case presented the time relationships do not support the idea that chloroquine could have been toxic in this respect. There is no doubt that the patient's retinitis was due to chloroquine since more than 50 cases of this complication have been reported.[14]

Certainly a pacemaker would have been useful had it been available.

Summary. A case is presented in which the patient had systemic lupus erythematosus with severe myocarditis which caused severe cardiac conduction derangements and death. This is an unusual feature of SLE but again demonstrates the remarkable variability of this disease.

413 Main Street (53094).

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UPPER GASTROINTESTINAL HEMORRHAGE FROM CARCINOMA OF ESOPHAGUS

Doctors Larry C. Carey, Joseph C. Darin, Leonard W. Worman, and Kenneth J. Wagner (BA) of Milwaukee, presented a paper before the 72nd Annual Session of the Western Surgical Association at Colorado Springs in November 1964. It was entitled "Upper Gastrointestinal Hemorrhage From Carcinoma of Esophagus."

In a series of 139 patients with esophageal malignancy at the Marquette University affiliated hospitals, 6 were found to have hemorrhage as a prominent feature of their illness. All had hematemesis and all were or could have been controlled nonsurgically. No major vessel erosion accounted for the bleeding in these cases. Initial clinical diagnosis was erroneous in all of the patients. In these 6 cases, 50 per cent did not have the usual history to suggest esophageal cancer. In the other 3 cases, hemorrhage may have deterred the clinicians from the correct diagnosis. All patients with upper gastrointestinal hemorrhage unexplained by radiographic means and all who have esophageal complaints should have esophagoscopy.

The paper was published in the April 1965 *Archives of Surgery*.—V. S. Falk, M.D., Edgerton.

HEART MUSCLE, STENOSIS AND SURGERY COVERED IN AHA MONOGRAPH VOLUMES

Three new volumes of special interest to cardiologists, surgeons, investigators, hospital staffs, medical schools and medical libraries have been published as part of the American Heart Association's Monograph Series. They are:

Structure and Function of Heart Muscle, Volume 9 in the series, consisting of the proceedings of a symposium held in 1964 to review existing knowledge, clarify differences, and point out problems still to be solved in this area;

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Cardiovascular Surgery 1964, Volume 11 in the series, consists of 26 papers presented at the Association's 1964 Scientific Sessions in Atlantic City.

Volumes 9 and 11 may be obtained at $3 each, and Volume 10 at $2.50, from local Heart Associations or the Association's national office, 44 East 23rd Street, New York, N. Y., 10010.

UNIT TO TEST CHEST PAIN DIAGNOSIS DEVELOPED BY AHA AS A TEACHING AID

A table-top model of the self-testing unit, "Differential Diagnosis: Chest Pain," has been developed by the American Heart Association. It consists of four panels, each illustrating a medical case. X-rays and electrocardiograms on each panel correlate with a written case history. After reading the case histories and studying the pertinent laboratory data illustrated on the panels, the physician answers multiple choice questions about each case and then checks his own answers.

The unit, prepared by the AHA Committee on Medical Education, was designed for use at local or state medical meetings, as a teaching exercise for medical students and house officers and as a basis for discussion at hospital staff meetings. In many instances arrangements may be made to borrow it through local Heart Associations. Inquiries about purchase should be directed to the AHA national office, 44 East 23rd Street, New York, N. Y., 10010.

* * *

In 1964, ethical drug manufacturers introduced 162 new products to the market, 51 fewer than in 1963, though they spent over $30 million more ($298.1 million) on research.

CASE REPORT

Giant Leiomyosarcoma of the Mesentery

By WILLIAM B. GALLAGHER, M. D., La Crosse, Wisconsin

■ YANNOPOULOS AND Stout[1] in a definitive study of primary mesenteric tumors collected 44 contemporary cases. Fifteen were malignant and 29 benign, divided among seven histologic types: (1) Fibromatosis [12 cases], (2) Xanthogranulomas [6 cases], (3) Lipomatous tumors [6 cases], (4) Smooth muscle tumors [7 cases], (5) Vascular tumors [5 cases], (6) Neurofibromas [3 cases], and (7) Mesenchymomas [2 cases].

Of the seven smooth muscle tumors of the mesentery, two were benign (leiomyomas) and five malignant (leiomyosarcomas). Four of the five leiomyosarcomas were very large—one measured 37×36×13 cm and weighed 8,450 gm. They had produced symptoms by their bulk. Microscopically three were round-cell and two were spindle-cell sarcomas. One metastasized and three had peritoneal implants. Only one of these five patients was alive, and he had persistent disease.

CASE REPORT. A 60-year-old white man had been having intermittent abdominal pain for nine years. The pain interfered with his ability to work as a laborer. He was a heavy beer drinker. In 1955 and several times subsequently, a mass in the right upper quadrant was palpated. It was believed that he had cirrhosis of the liver, although this was never confirmed by liver biopsy. Liver function studies were equivocal.

In February 1964, he was hospitalized because of extreme weakness. His abdomen had become massively distended, although he had a weight loss of 80 lb. He complained of a feeling that if he leaned forward, he would topple over from the weight of his abdomen. In spite of this, his appetite was good and his intestinal and urinary tracts functioned normally.

The patient appeared cachectic and his abdomen protruded prominently. Nevertheless, his hemoglobin level was 10.8 gm/100 ml and his sulfobromophthalein test only 3%. A paracentesis was done and dark blood obtained. Intravenous urograms and complete gastrointestinal x-ray studies were negative, as was sigmoidoscopic examination.

Fig. 1—Appearance of opened abdomen.

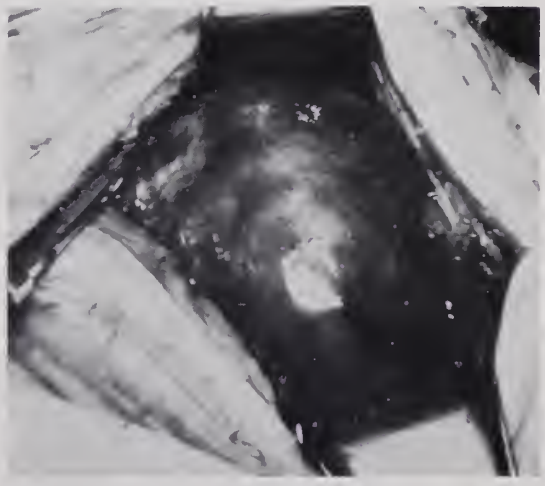


Fig. 2—The tumor.

Fig. 3—Mobilization of tumor showing attachment to mesojejunum.

Fig. 4—The tumor removed and the defect in jejunum closed.

A laparotomy was performed under endotracheal anesthesia with a preoperative diagnosis of "probable carcinomatosis."

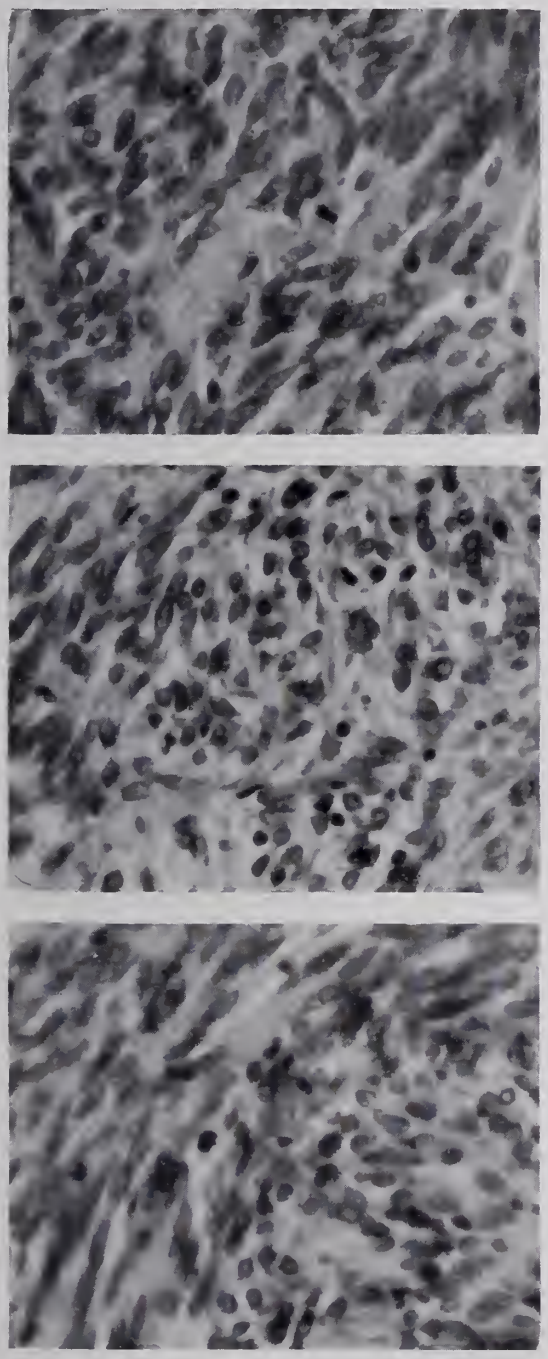
The abdomen was filled by an enormous black tumor extending from the liver to the bottom of the pelvis (Figs 1 and 2). All the viscera lay behind it. In attempting to mobilize the tumor, it was manually broken and a large amount of dark blood similar in appearance to that obtained at paracentesis poured out. The tumor shrank considerably and it was at length manipulated and lifted out of the abdomen. Its only attachment was by a pedicle to the junction area of the jejunum and its mesentery (Fig 3). The pedicle was severed with a margin of jejunal wall and the defect closed (Fig 4). No liver metastases or peritoneal implants could be seen. Saline lavage was carried out.

The patient's blood pressure dropped during the procedure but responded to the administration of 1,000 ml of whole blood and vasoconstrictors. He received 45 mg of triethylenethiophosphoramide (thio-TEPA) in divided doses after surgery.

Fig. 5—Below are low-power views exhibiting cellularity and typical whorling, interlocing pattern.

Grossly the tumor had a capsule which was torn; the central portion of the tumor mass was cystic, collapsed and bloody. The substance of the tumor itself was soft, dull white in color, and interspersed with blood-filled spaces which apparently accounted for the dark color of the mass. The tumor measured 25×25×12 cm. Unfortunately it was not weighed.

Fig. 6—Below are high-power views revealing mitotic figures, large elliptical nuclei, and minimal nuclear anaplasia.



Sections revealed a cellular tumor with an interlacing, whorled pattern. The tumor cells were large with elliptical nuclei, minimal anaplasia, and occasional mitotic figures. Areas of hemorrhage were present. The lesion resembled a fibrosarcoma but the gross softness of the tumor and the relatively slight degree of nuclear anaplasia was more consistent with a leiomyosarcoma* (Figs 5 and 6).

His postoperative course was uneventful and he was discharged a week later. Eighteen months postoperatively he is getting along well.

* Report by Ruth Dalton, M.D.

Discussion. Rankin and Major[2] considered mesenteric tumors as possibly arising from displaced remnants of the genital gland, wolffian body or its duct, or from the müllerian duct. Yannopoulos and Purdy[1] point out the rarity of embolic metastases from mesenteric tumors, but "particularly the smooth muscle variety have given rise to peritoneal implants . . . whether benign or malignant most tumors in the mesentery tend to grow to a large size . . . the mobility of the mesentery often permits a tumor to grow to a large size before it causes any symptoms other than a palpable mass . . . Because so few of these tumors have embolic metastases it (is) worthwhile to attempt the removal of even large tumors whether or not there are peritoneal implants."

There is an exaggerated reluctance by surgeons today to perform exploratory laparotomies on patients without a clear-cut diagnosis. Roentgenological investigations can entirely miss formidable pathology. If this patient had been an abstemious woman, she would have been opened up long ago with a preoperative diagnosis of "probable ovarian cyst."

Summary. A 60-year-old man with massive abdominal distention, anemia, weight loss, and negative x-ray studies was found at operation to have a resectable giant leiomyosarcoma of the mesentery. This appears to be the sixth such case reported.

312 State Street.

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A Total Pancreatic Fistula

CASE REPORT

Treatment by Sphincterotomy and Intubation of the Pancreatic Duct

By GEORGE F. PRATT, M.D., Rhinelander, Wisconsin

■ MOST PANCREATIC fistulas that follow injury tend to heal after a time and are not serious problems. Other rarer but more serious fistulas are characterized by persistent voluminous drainage, progressive weight loss, and pain. Since this type is uncommon, it seems worthwhile to report the following case:

CASE REPORT. On October 20, 1962, a 20-year-old man was shot, at a distance of 30 feet, with a "sawed-off" shotgun. Six heavy buckshot penetrated his body, causing laceration of the left lung and hemothorax. There was also perforation of the diaphragm, stomach, duodenum, liver, pancreas, and vena cava, and there were compound fractures of the right first metacarpal and left ulna. All of these injuries, other than that of the pancreas, responded to customary surgical management, and therefore are not described at length.

In order to repair the duodenum and the vena cava, the duodenum was mobilized. The posterior surface of the head of the pancreas appeared to be superficially lacerated with slight oozing of pancreatic juice. As visualized from the lesser peritoneal sac, the body of the pancreas was uninjured. Penrose drains were placed near the head of the pancreas, but a major pancreatic fistula was not expected.

In the days following surgery, there was a large amount of bile-stained drainage, thought at first to be coming from the liver wound. In spite of antibiotics, there were daily temperature elevations to 102 F. Abdominal pain after eating was a frequent complaint which led to inadequate food intake and weight loss.

On the 13th postoperative day, the Penrose drains were replaced by a suction catheter, in order to allow collection of all of the drainage and to prevent skin irritation. On the 20th postoperative day, the drainage, which had varied in volume from 800 to 1,400 ml daily, became crystal clear. On analysis, 100 ml contained 27,800 amylase units (iodometric method). Attempts to give it by mouth or by nasogastric tube were sometimes successful, sometimes followed by vomiting.

On the 30th postoperative day and for the next five days, the patient developed severe epigastric pain, vomiting, and an abdominal mass. Attempts to obtain better drainage by dilating the fistula were unsuccessful. On the 36th day, with greater spontaneous drainage from the fistula, the mass disappeared and the symptoms diminished.

Because of continual anorexia, pain, and loss of pancreatic juice, the patient's weight had declined from 145 to 100 lb by the 47th postoperative day. A roentgenogram revealed that the tortuous tract was connected to the main pancreatic duct about one inch from the ampulla of Vater. The dye first filled the pancreatic duct, then the common duct, and finally the duodenum.

The patient's rapidly deteriorating condition made it essential to reestablish free pancreatic drainage into the gastrointestinal tract. Many procedures were evaluated, but the approach to the problem advocated by Doubilet and Mulholland[1,2] seemed most applicable to these circumstances.

Accordingly, on December 7, 1962, seven weeks after the injuries were sustained, the common bile duct was opened and a probe was passed through the sphincter of Oddi. A sphincterotomy was done and the main pancreatic duct was intubated with a small plastic tube. When clear drainage was obtained, the opposite end of the tube was brought up the common duct and out the choledochotomy along with a t-tube. A cholecystectomy was performed.

Recovery was slow. His weight decreased to 96 lb by the 12th postoperative day. It was not until the 14th postoperative day that he began to eat well and to gain weight.

During this time, drainage from the plastic tube varied from 50 ml or less to as much as 950 ml daily. On the 17th postoperative day, the t-tube and plastic tube were removed. No further drainage occurred.

Rapid improvement ensued. The patient had become addicted to meperidine (Demerol) but withdrawal was accomplished with minimal difficulty. Four weeks postoperatively he had gained strength and weighed 119 lb. He was dismissed from the hospital.

There was no difficulty until May 1, 1963, when he developed epigastric pain. An abdominal mass thought to be a pseudocyst was palpable. Its location in the lesser peritoneal sac was suggested by barium studies of the stomach and colon. Five days later the pseudocyst was internally drained by transgastric cystogastrostomy. He has had no further trouble related to the pancreatic injury.

Doctor Pratt is a member of the surgical staff, Warner S. Bump Medical Group, Rhinelander, Wisconsin.

Discussion. Stone et al[3] and Culotta et al[4] emphasize the use of adequate drainage, especially a sump drain, at the time of the original injury. It is possible that the early use of a sump drain here would have brought about a less stormy course. Many authors discourage attempts to repair the injured duct or to implant the pancreas into the gastrointestinal tract at the time of the original surgery in the multiply injured patient. Nevertheless, resection of the distally injured pancreas may be feasible.[3,4] There are also instances of isolated injury to the pancreas, especially by blunt trauma, where immediate implantation of the severed pancreas has been successful.[5]

Doubilet and Mulholland[1] reported a patient who was able to maintain adequate nutrition for two years by drinking all of the juice from his distal pancreas. Quite the opposite was true of our patient, who was not regularly able to tolerate receiving his pancreatic juice by tube feeding or by mouth.

When it became apparent that an operation to establish internal drainage would be necessary, several procedures were considered. Direct implantation of the fistula into the intestine was rejected, because the fistula was already stenotic, tortuous, and probably inflamed. Again, probable inflammation and the posterior location of the injured duct made its direct anastomosis to the intestine (Cattell and Warren[6]) likely to be difficult. Careful consideration was given to the possible use of retrograde drainage, established by implanting the stump of the transected tail of the pancreas into a Roux-Y. This was described by Puestow[7] in the treatment of chronic pancreatitis, and later used by Borgström[8] in the treatment of a serious pancreatic fistula. This might have been successful. At the time, the simplest procedure seemed to be that of Doubilet and Mulholland, namely, sphincterotomy and intubation of the pancreatic duct at the ampulla of Vater.[1,2] Removing the obstruction caused by sphincter spasm and using a plastic tube as a stent in the duct of Wirsung led to closure of the fistula and to restoration of the patient's good health. Subsequent duct obstruction caused the formation of a pseudocyst which was successfully treated by transgastric cystogastrostomy.

Summary. The management of a serious pancreatic injury is described. Other possible methods of management are listed.

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FILM: "REPRIEVE—HEART DISEASE CONTROL PROGRAM

General Dwight D. Eisenhower tells how sensible living habits and adherence to doctors' orders have enabled him to recover from a heart attack in a 16-millimeter color motion picture, called "Reprieve," sponsored by the Heart Disease Control Program of the Public Health Service, U. S. Department of Health, Education, and Welfare.

Other heart patients who tell their stories through this film include a farmer, a mechanic and a banker —all from Salisbury, a fishing and farming community on the Eastern Shore of Maryland.

Executive producer and narrator of the film is Dr. Murdock Head, Director of the Airlie Foundation. This film is now available for public showing through the Public Health Service.

Purpose of the 22-minute film is to inform the general public that most of the million-plus men and women who survive a heart attack each year can return to active life by following a few sensible rules of living.

For showings to groups, prints of the film, "Reprieve," can be obtained on loan free of charge by writing to the Public Health Service Audiovisual Facility, Atlanta, Ga. 30333.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: EDWARD A. BIRGE, M.D.
Milwaukee, Wisconsin

Case Presentation.* A 68-year-old obese white woman was admitted to the hospital for the second time in January 1963 with a chief complaint of being "short of breath." In May 1962 she had had what was described as "flu," with fever, cough, dizziness, and nausea, during which time she noted progressive breathlessness. The fever, nausea, and dizziness subsided in approximately two weeks, but her shortness of breath and cough persisted. She had no greater shortness of breath at night while in bed, and she slept quite comfortably on one pillow. Her cough was mild and only occasionally productive of a small amount of mucoid yellow-greenish sputum. She did not recall ever having shortness of breath or cough prior to this time. She was told she was hypertensive.

Approximately two months after her illness began, she noted oppressive anterior chest pain associated with effort; but both this and her dyspnea were relieved by several minutes of rest. She had no past history of hypertension, renal disease, or a family history of hypertension. There was no pedal edema or hemoptysis. She had had pneumonia once in childhood. By December 1962 she had become severely debilitated due to her dyspnea, which occurred even when she was walking from one room to another at home. At this point she was admitted to the hospital.

Physical examination revealed a markedly obese, tachypneic and dyspneic white woman, with a blood pressure of 206/122 mm Hg, pulse rate of 78 with a regular rhythm, and a weight of 173 lb. Funduscopic examination showed normal optic disks, with minimal generalized arteriolar narrowing. Neck veins were not distended in the supine position. There was no dullness on percussion of the chest. Expansion and tactile fremitus were described as normal. There were diffuse fine crepitant rales scattered throughout both lungs. No pleural rub or wheezes were heard. Cardiac size was difficult to assess because of the patient's obesity and pendulous breasts, but the heart rate and rhythm were normal and no murmurs were heard. No organomegaly, areas of tenderness, or masses were palpable within the abdomen. Examination of the extremities was normal.

The urinalysis showed a specific gravity of 1.011, with no proteinuria or glycosuria. There were many white blood cells (WBC) per high-power field (HPF). A repeat urinalysis 12 days later gave a specific gravity of 1.013, with 2 to 3 red blood cells and occasional WBCs/HPF. The hemoglobin level was 15.1 gm/100 ml, hematocrit reading 48%, and WBC 10,850/cu mm, with a differential count of 64 segmented neutrophils, 2 stab forms, 30 lymphocytes, 3 monocytes, and 1 eosinophil. The fasting and two-hour postprandial blood sugar values were 100 and 120 mg/100 ml respectively. Blood urea nitrogen (BUN) was 19 mg/100 ml, total serum proteins 6.07 gm/100 ml, with 2.93 albumin. Serum calcium was 4.6 mEq/L and serum phosphorus 4.2 mg/100 ml. Serology was negative. A bromsulphalein (BSP) test showed 12% dye retention after 45 minutes. The alkaline phosphatase was 9 King–Armstrong units. A phenolsulfonphthalein (PSP) test showed 19.7% dye excretion after 15 minutes, with a urine volume of 155 ml. Serum electrolytes were as follows: total carbon dioxide (CO_2) 29.5, chloride 98.5, sodium 139, and potassium 4.4 mEq/L; pH serum 7.37. Skin tests with histoplasmin, blastomycin, coccidiomycin, and intermediate purified protein derivative (PPD) were negative at 48 hours. Sputum for routine smear for acid-fast bacilli was negative.

Pulmonary function studies gave the following results: vital capacity 880 ml (predicted 2,480 ml); total vital capacity of 880 ml was expired after one second; maximum breathing capacity was 35 liters per minute, with a predicted value of 72 L/min; resting

* From Milwaukee Hospital.

arterial oxygen saturation was 96%, with a fall to 86% after 90 seconds of exercise. Electrocardiographic studies showed a sinus rhythm, with a rate of 95 beats per minute. The PR interval was 0.17 seconds, QRS 0.07 seconds; T-inversion was present in V-1 through V-3, with flattening of T at V-5 and V-6. Chest x-ray film was read as showing a normal-sized heart. The diaphragm was high, and the lungs were poorly aerated. Scattered old fibrotic lung changes were present. There was no effusion.

The patient was treated with digitalis, a mercurial diuretic, an expectorant, and was given a brief trial with demethylchlortetracycline. Symptomatically she was not significantly improved and had no weight loss from the diuretic. She was discharged on digitalis, and at home progressively deteriorated to a point of dyspnea at rest. On one occasion early in January 1963 she had blood-tinged sputum, but had no chest pain or increased breathlessness at that time. Her respiratory symptoms were otherwise unchanged from the time prior to her first hospitalization. She had no somnolence. She had urinary urgency and frequency, with terminal dysuria and stress incontinence.

She was readmitted to the hospital in January 1963 when physical examination revealed her condition as essentially unchanged from that of December. On admission her blood pressure was 180/110, pulse rate 90, and respirations 32 per minute. Nailbeds were cyanotic. Neck veins were flat in the supine position. The diaphragm was high and no respiratory lag could be demonstrated, but the chest excursions were restricted. Diffuse high-pitched crackling rales were heard throughout both lung fields. Cardiac rate and rhythm were normal. The second sound at the pulmonic area was greater than that over the primary aortic area.

Pelvic examination revealed a second degree cystourethrocele. Rectal examination was normal. Urine specific gravity was 1.010 and there was no proteinuria, glycosuria, red cells, or pus. Hemoglobin level was 14.6 gm/100 ml, hematocrit reading 43.5%, WBC 8,700 with 60 segmented neutrophils, 35 lymphocytes, 3 monocytes, and 2 eosinophils. BUN was 11 mg/100 ml. Total proteins were 6.55 gm/100 ml, with 2.8 albumin. Serum electrolytes were as follows: pH 7.45; total CO_2 31, chloride 103.5, sodium 144, and potassium 4.25 mEq/L. One lupus erythematosus (LE) preparation was negative. Routine sputum culture again showed viridans streptococci and saprophytic micrococci. An acid-fast bacillus (AFB) culture was negative. Four sputum specimens for cytology were negative. A sputum specimen submitted for periodic acid Schiff (PAS) stain showed only an admixture of mucus and debris. Her vital capacity was 760 ml, with 100% expiration in one second. Maximum breathing capacity was 35 L/min before and 30 L/min after a bronchodilator. Chest x-ray films and fluoroscopy of the chest showed high diaphragms, with poor motion. Fibrotic changes within the lung parenchyma were unchanged from previous examinations. An intravenous pyelogram was normal.

During this second admission, the patient's blood pressure was generally normal, fluctuating between 150/90 and 130/80. A second strength PPD test gave 1 cm of erythema, with only a suggestion of induration at 48 hours. A week after readmission, a right scalene node biopsy was performed under local anesthesia, during which the patient suddenly became tachypneic. Following the procedure, she remained tachypneic, developed circumoral cyanosis, and was extremely apprehensive. Positive pressure breathing with a Byrd apparatus improved her color, but the apprehension and tachypnea persisted. She developed considerable upper abdominal distention, with epigastric tympany, and had a large emesis of green fluid, following which she was intubated with a nasogastric tube.

A tracheostomy was performed early the next morning, and positive pressure therapy with Byrd apparatus and intravenous hydrocortisone was again instituted. However, the patient had a downhill course, with marked tachypnea, deepening cyanosis and hypotension, and in spite of all measures, she died the following morning.

Dr. Edward S. Friedrichs: When I was preparing for this diagnostic exercise, Dr. Raymond Headlee of our staff loaned me the proceedings of a conference held at the University of Michigan in May 1963. It was a conference about "The Diagnostic Process," sponsored by the Public Health Service and the Biomedical Data Processing Training Program of the University of Michigan. The program maintains an interest in the use of computers for diagnosis of medical disease. The proceedings were in-

teresting and provoking. They took a lengthy view of the manner in which we "pigeonhole" the afflictions suffered by human beings into disease categories—the classification of disease. A variety of approaches are used simultaneously — etiologic, epidemiologic, histologic, and others. On the other hand, many disease entities are purely descriptive; that is, syndromes, which help us but little to understand cause, not to mention treatment.

The diagnostic process abstracts certain facts from the patient's case to make a generalization, which is labeled "The Disease"—a generalization which avoids looking at the individualistic aspects of the ill patient. But, as we all know, every patient *is* an individual, a human being suffering from dis-ease *(sic)*. The dilemma is a real one. The diagnostic process, by its very nature, trains us to avoid looking at the individual, the idiosyncratic aspects of the disease process in this patient, and to concentrate on the common aspects of the disease entity, learned from experience with other patients afflicted in a "similar" way. It seems wise, therefore, to expand our concepts of medical care beyond the point of diagnosis, beyond the point of finding an accepted treatment regimen, to include recognition of and attention to the individual characteristics of the human being we are treating. This would mean applying our observation powers and understanding of the patient's behavior, thoughts, and feelings, and making them an integral part of his therapeutic regimen.

CPC protocols have the distinct characteristic of not sounding like a description of a human being. Certainly the CPC is a valuable teaching method in medical education, but it usually describes a body and a disease, and not a human being. The challenge is growing in medical education to apply the less "measurable" aspects of human behavior to the "measurable" aspects of diagnosis and treatment.

The patient presented in this conference is a 68-year-old woman who suffered and died over a nine-month period from an illness characterized by progressive respiratory failure. The disease process first became symptomatic as a "flu-like" syndrome of fever, cough, dizziness, and nausea. Cough and dyspnea continued, chest pain and hypertension intervened, and the course was steadily and relentlessly downhill. Significant abnormal laboratory data were limited to mild "polycythemia," pyuria, elevated postprandial blood sugar, disturbed serum proteins and BSP dye retention. We come, then, to the most striking abnormal test item—the pulmonary function studies. These were a vital capacity of 880 ml, the one second timed vital capacity 100% of the total, and maximum breathing capacity 50% of normal. With these studies in mind, the chest x-ray findings are immediately pertinent.

Dr. J. E. Garman: The first chest film, taken in late November 1962, showed a diffuse nodular and linear process throughout both lung fields. The infiltrates were fibrotic in appearance and more prominent in the subpleural areas. The diaphragm occupied a high position and was reported to have a limited range of motion at fluoroscopy. No area of collapse or frank consolidation was identified. The heart was not grossly enlarged and there was moderate senile widening and elongation of the aorta. A film obtained 11 days later, early in December 1962, was unchanged in appearance. On a final film, in late January 1963, there was minimal increase in the left lower lobe density.

Doctor Friedrichs: Thus we see contraction of lung volume, fibrosis, and minimal roentgenologic progression correlating with rapid clinical deterioration. The absence of adenopathy is important.

Since I am much closer to my days as a medical student than I am to my days as an experienced clinician, at first reading of the protocol I looked closely for a "pathognomonic sign." Finding none, I sought out the more unusual manifestations as a starting place. The ventilatory studies were striking. The ventilatory defect was restrictive rather than obstructive, indicating little or no upper airway obstruction but a restricted compliance of lung and/or chest. The x-ray studies support a restrictive shrinking process of lung tissue. Arterial oxygen desaturation with minimal exertion in these circumstances strongly suggests an alveolar-capillary block of oxygen transport.

Also attracting my attention was the hyperglobulinemia, the electrocardiographic evidence of right ventricular strain, and the many, many significant negative results from the physical examination and the lab-

oratory. I had the greatest difficulty with the systemic hypertension and the elevated BSP. Common extrahepatic causes of BSP retention are renal insufficiency and fever, neither of which was present. Persistent diastolic hypertension was found in the absence of other evidence of hypertensive cardiovascular disease, such as retinopathy, albuminuria, and left ventricular hypertrophy.

I rejected the significance of the two-hour postprandial blood sugar since mild disturbances of glucose tolerance are common in the obese. I hesitate to call this finding diabetes mellitus, although it certainly represents a disorder of carbohydrate metabolism. To my mind, the most significant negative findings were lack of fever, cough but not much sputum, benign sputum cultures, no right ventricular failure despite pulmonary hypertension, normal serum electrolytes (an arterial pH and CO_2 would perhaps have been more valuable in understanding the acid-base balance), lack of skin, joint, special sense organ, glomerular and hematologic involvement. Evidence for primary heart disease is lacking. The findings are consistent with cor pulmonale.

I would like to discuss several disease groups, beginning first with pulmonary embolism. Does the respiratory failure reflect multiple small pulmonary emboli? This condition frequently is unrecognized and gradually depletes respiratory reserve. In rejecting this diagnosis, one notes the absence of a pleuritic unilateral chest pain, acute episodes of dyspnea, and recurrent hemoptysis. Dyspnea was limited to exertion alone.

The one report I located of the ventilatory studies in multiple recurrent pulmonary emboli showed primarily a perfusion defect rather than a diffusion or restrictive defect. Perfusion ventilation defects are created when blood supplies an area of lung which is not ventilated with air. Oxygen saturation climbs no higher than 95 to 96%, even with 30% oxygen inhalation. This patient maintained an oxygen saturation of 96% on room air, so we are dealing here with an alveolar-capillary block.

Thought was given to various granulomatous diseases, tuberculosis and fungus. Skin tests and sputum cultures failed to support these. The lung findings of limited nodularity and marked fibrosis would be consistent only with a chronic granulomatous infection of many years' duration. Our patient's disease process was apparently short in duration and previous history of pulmonary disease was limited. Slight skin induration with the second strength PPD is not a positive test. Sarcoidosis deserves serious thought, but several items are against it. The literature suggests that this age group tends not to develop sarcoidosis, and, when it is found here, it is the end result of a chronic, indolent, fibrotic process, not the abrupt illness our patient had. In addition, the calcium and alkaline phosphatase values were normal, and no evidence of lymphadenopathy or uveoparotid disease was described.

Thesaurosis is a granulomatous and fibrotic pulmonary process which some investigators feel is related to the inhalation of hair spray containing polyvinylpyrrolidone. There is a current battle in the literature as to whether these cases can be histologically differentiated from chronic fibrotic sarcoidosis. Other inhalation granulomatous diseases such as asbestosis, berylliosis, and silicosis were rejected by the absence of history. Histologically, berylliosis is identical to sarcoidosis, and the history must be used for this distinction. Wegener's granulomatosis may be considered, but there was no evidence of other vasculitis, glomerulitis, or renal failure, which is the common cause of death.

Leaving the granulomatous diseases, we turn to the collagen diseases. Once again the lack of involvement of other organs is pertinent. Interstitial pulmonary fibrosis is associated with rheumatoid arthritis, lupus erythematosus, and 10% with scleroderma. There are no other findings indicative of these disease processes. The diagnosis of periarteritis nodosa has been offered when there is a polyarteritis limited to the lungs. Primary pulmonary hypertension, a vasculitic or thrombotic disease, leads promptly to cor pulmonale and right ventricular failure. In our case the pulmonary hypertension and right heart strain were "latecomers." Brief attention was given to neoplastic diseases such as lymphangiitic spread of carcinoma, but I would not expect the shrinkage of the lung volume seen. Certainly the compliance decreases with lymphangiitic spread, but there would have to be a marked fibrotic reaction, such as that produced by radiation therapy, to cause such a diminution in volume. Alveolar cell carcinoma tends

to form distinct infiltrations and mass lesions on chest x-ray films.

A miscellaneous group should at least be mentioned. Histiocytosis X, an infiltration of histiocytes with fibrotic changes, is a very rare condition. Pulmonary alveolar proteinosis is generally a biopsy diagnosis and I supposed this was the diagnosis considered when the sputum PAS stain was performed. A radiating perihilar pulmonary infiltration rather than a more diffuse fibronodular infiltrate would be expected. The most unusual condition I encountered is a diffuse pulmonary muscular hyperplasia, in which muscular elements interfere with alveolar-capillary diffusion and compliance.

At last I am faced with a pertinent, though perhaps "waste-basket" diagnosis, idiopathic pulmonary fibrosis—known by the eponym "Hamman–Rich." Hamman and Rich described this histologic entity in 1944 in the JOHNS HOPKINS BULLETIN. Since then many investigators have supported their observations with a large number of patients. The original cases manifested a short course (a matter of weeks), but subsequently other authors have described many cases with identical histology and longer clinical courses lasting from one to six years. A progressive type of pulmonary fibrosis, interstitial, with alveolar cell changes, is described. How is this case consistent with the diagnosis of idiopathic pulmonary fibrosis? The ventilatory defect is restrictive rather than obstructive. There is a change in the compliance of the lung and an alveolar–capillary block rather than a perfusion ventilation disturbance. A shrinking of the lung mass, loss of motion of the diaphragm, and loss of observable chest expansion are all seen in idiopathic pulmonary fibrosis. The pathology is limited to the lungs, with the heart secondarily affected.

In one series of idiopathic pulmonary fibrosis, 25% associated the onset of the disease with a febrile illness of seemingly benign nature, although fever was not prominent in the course of the subsequent progressive pulmonary failure. Cough with minimal sputum is usual, and occasional hemoptysis is described. Hyperglobulinemia, particularly the gamma globulins, was a very common finding. Right heart strain occurred, not only by the loss of vascular cross-section in the pulmonary circulation but also through hypoxia itself creating a reflex pulmonary hypertension, right heart hypertrophy, and failure. The variable duration of the disease is consistent with the nine-month history of this patient.

I have not mentioned systemic hypertension. It was one of the details that troubled me in the beginning. Three of the original four Hamman–Rich cases had marked diastolic hypertension when first seen. Other reports do not record systemic blood pressure. The abnormal BSP I would relate to a chronic hypoxia. An association between chronic hypoxia and elevation of serum enzymes has been described. A series of hypoxic patients were studied and the enzymatic evaluations of serum glutamic oxaloacetic transaminase (SGOT) and lactic dehydrogenase (LDH) were much more consistent with the degree of hypoxia than with the incidence or severity of cor pulmonale and failure. The assumption was that hypoxia was directly related to a central lobular necrosis and elevations of the serum enzymes contributed by the liver.

In conclusion, my clinical diagnoses will be: (1) idiopathic pulmonary fibrosis, (2) organic heart disease with cor pulmonale manifested by right ventricular hypertrophy, pulmonary hypertension and minimal, if any, left ventricular hypertrophy (despite the registered systemic hypertension), (3) central lobular hepatic necrosis and fibrosis, and a moderate chronic pyelonephritis. The immediate cause of death? Pulmonary embolism seems very possible, but the terminal state is also consistent with progressive right heart failure.

Dr. F. E. Murray: I want to make one very brief comment regarding sputum PAS stains. In 1960 Doctor Mason and Dr. D. Carlson published a paper in the AMERICAN JOURNAL OF CLINICAL PATHOLOGY on the diagnostic features of sputum stained by this technique in a patient who later proved to have alveolar proteinosis. In some cases it is of value.

Dr. E. A. Birge: As Doctor Friedrichs has concluded, this is a case of interstitial pulmonary fibrosis, or Hamman–Rich syndrome if you wish. At the time of autopsy, the most significant findings were associated with the heart, lungs, and liver. I will discuss them in reverse order and not in the order of their importance.

The heart was slightly enlarged, weighing 360 gm. The left ventricle was not enlarged, but the right ventricular wall measured 5

mm in thickness, which would be considered definitely hypertrophied. The clinical evidence for right ventricular hypertrophy can be confirmed morphologically. The liver was somewhat enlarged and weighed 1,750 gm. It was yellow, greasy, and homogeneous. On section it showed a tremendous amount of fatty metamorphosis, which I would attribute to extreme obesity rather than to any toxic changes. The retention of the BSP might be due to the fatty metamorphosis. It could also be due to a change in circulation. If there is any cardiac failure, there will be retention of BSP, as you know. The kidneys were very slightly diminished in size. They weighed 120 gm apiece and showed a few arteriosclerotic scars. Microscopically the only change that I could demonstrate was an occasional arteriole which was hyalinized and which had a minimal diminution in the size of its lumen. It did not fit the usual pattern of a nephrosclerosis, nor did I see any significant pyelonephritis.

Now let us turn our attention to the lungs. Both lungs were heavy; the right weighed 620 gm, the left 530. At the time of autopsy I estimated that about 10% of the lungs were air-containing. It is rather hazardous to say that only this amount of lung tissue was functioning during life, because the patient received oxygen terminally by catheter, so there would tend to be some collapse. The patient was fat and she was flat on her back, so this would also tend to squeeze air out. I think, however, that one can safely say that well over 50% of the lung was noncrepitant, fibrotic, and nonfunctioning. The lung was nodular to palpation, although when cut into the nodules disappeared.

On fresh section the noncrepitant areas were hemorrhagic, firm, uniform, and slightly moist. After fixation, it was possible to pick out many 1-to-2-mm-sized nodules which were scattered through these solid areas. These were white and resembled miliary tubercles or a disseminated carcinoma. The bronchi were not dilated. Their mucosal surfaces were moist and somewhat edematous. The hilar lymph nodes were not enlarged and appeared to be grossly normal. There was the usual anthracosis. I think we may now turn to the sections.

If one first examines the crepitant portions of the lung, one sees that the alveolar septa are thin, slightly congested, but otherwise not remarkable. In a few places, the alveoli contain pink-staining fluid, probably representing terminal pulmonary congestion secondary to heart failure. As we move from the crepitant areas into the subcrepitant and noncrepitant areas, we find that the alveolar septa become markedly thicker, being three to four times the size of those

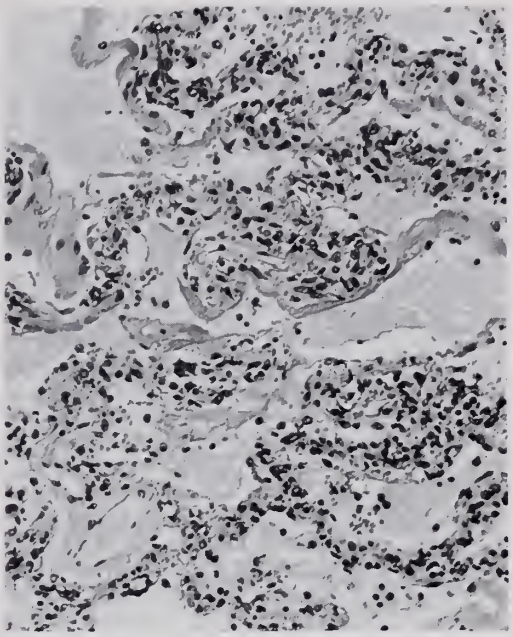

Fig. 1—Amorphous membrane partially lining alveoli. x100.

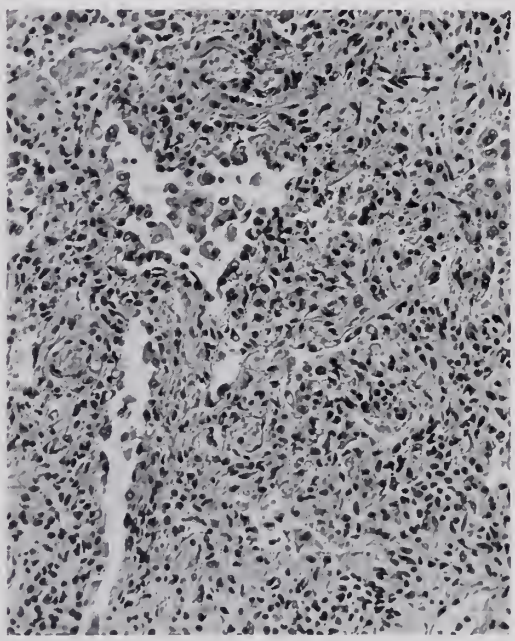

Fig. 2—Interstitial fibrosis with obliteration of alveoli.

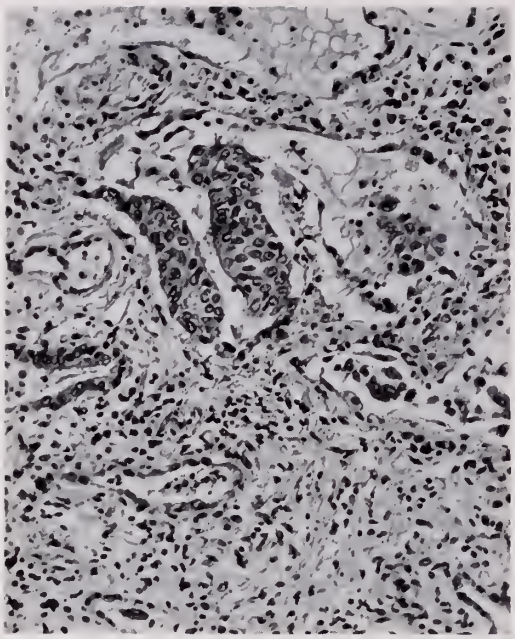

Fig. 3—Metaplasia of alveolar epithelium.

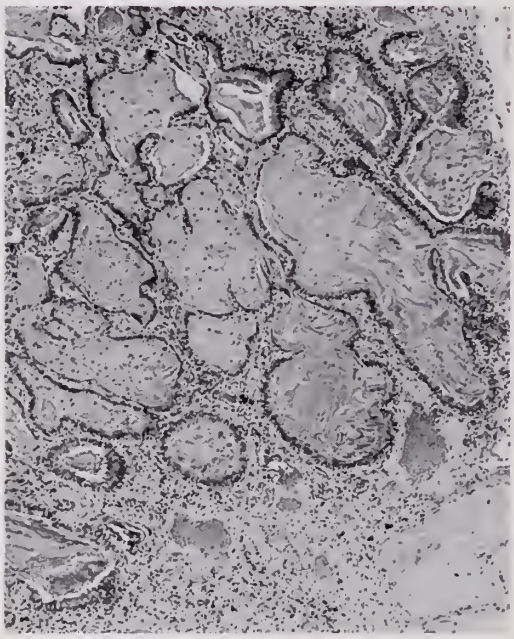

Fig. 4—Histologic pattern of tumor-like nodules.

which were first demonstrated. The thickening is the result both of extreme vascular congestion and the deposition of mature fibrous tissue. Oxygen transfer is hampered not only by the thickening of the alveolar septa but also by the presence of a pink-staining amorphous membrane which partially lines some of the alveoli. Figure 1 is an example of such a membrane.

In addition, one finds that the layer of cells which normally lines the alveolus is swollen, and in some instances is being sloughed off into the alveolar spaces where the cells round up to become the more familiar heart failure cells. The alveolar spaces are seen to contain not only fluid but also small numbers of neutrophils in a few areas. One may also find some neutrophilic infiltration within the alveolar septa.

In other areas we find that the fibrosis has progressed to the point where it has largely obliterated the alveolar spaces. Figure 2 shows a few atrophic acinar-like spaces lined by a layer of cuboidal cells which presumably represent the original alveolus. The fibrous tissue shows a moderate amount of lymphocytic infiltration, but otherwise there is nothing distinctive about it. There are no areas of granulomata in any of the sections studied. If one examines the isolated alveoli in Figure 3, one finds that occasionally the cuboidal cells are metaplastic, assuming a more squamous or polyhedral appearance. In these metaplastic areas the cells are arranged in groups several layers deep.

In still other places one finds that there are large and small irregular acini which are lined by a layer of large columnar mucus-secreting cells. These cells are very similar to those which ordinarily line the bronchi and bronchioles. In some of these areas one can see apparent extension of the bronchiolar epithelium into adjacent alveoli. Most of these acinar-like spaces are filled with mucus, occasionally associated with small numbers of neutrophils (Fig 4). These apparently represent the tiny white tumor-like nodules which were found grossly after the lung had been fixed.

I do not believe that this is true neoplasia. Rather they represent the sort of abnormal epithelial proliferation which one often finds associated with chronic infection. Such tiny tumorlets are often found in chronic bronchiectasis. The larger columnar cells are similar to those which are found in pulmonary adenomatosis. However, you will recall that in sheep this pattern is apparently due to a virus infection of the lung.

In this section, stained by a trichrome stain, one sees the changes which we have enumerated brought out in rather more

vivid detail. In the areas of most marked fibrosis, one can see that some of the pulmonary arteries are undergoing an obliterative endarteritis. There is nothing in the sections, however, which would suggest that we are dealing with anything like a Wegener's granulomatosis. The changes which we see here are compatible with interstitial idiopathic pulmonary fibrosis.

The superimposition of the acute inflammatory changes which one sees in some of these sections would qualify this for the disease process known as "Hamman–Rich" disease. It is extremely difficult to assign any specific cause for pulmonary fibrosis in many instances. Like so many tissues, the lung is able to react to trauma only in a limited number of ways. If we arbitrarily eliminate those substances which produce a granulomatous reaction and confine ourselves to those in which the fibrosis is relatively diffuse and without the production of significant granulomata, we find that the histological pattern seen in this particular patient is also associated with other disease processes.

Diffuse fibrosis associated with acute and chronic inflammation and the presence of a hyaline membrane also occurs in drug toxicity (hexamethonium), allergic states (Farmer's lung) and following the inhalation of noxious gases or particles. In the latter two instances doubly refractile bodies may sometimes be found by examination under a polarizing microscope. No such bodies were found in the present case.

Summary. One can summarize this material by saying that the etiological diagnosis in a case of pulmonary fibrosis rests primarily upon the clinical history rather than upon the changes which can be demonstrated grossly and microscopically. The lung reacts in a similar fashion to a wide variety of traumatizing agents. The etiology of idiopathic interstitial fibrosis is not known. Various theories have been postulated, including the currently fashionable one of autoimmune disease. Since there have been some cases which have occurred in siblings, a genetic background has also been suggested. As far as I know, there is nothing which can be pinpointed as a cause.

The underlying problem of this patient was that of alveolar-capillary block due to an interstitial fibrosis. The current thinking in regard to Hamman–Rich disease is that this may represent the acute terminal phase of an indolent process which has been present for some time. I have no explanation for the patient's death. The one that Doctor Friedrichs gave is probably as good as any. In looking through the literature, sudden death, following minimal operative trauma, has been recorded on more than one occasion. Apparently these patients are in a very precarious state and are unable to withstand any additional degree of external trauma.

2200 W. Kilbourn Ave.

* * *

CLINICAL CENTER STUDY OF LIVER DISEASE OF UNCERTAIN ETIOLOGY

The cooperation of physicians is requested in a clinical study of liver disease of uncertain etiology being conducted by the Metabolism Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of interest for this study are patients with liver disease of uncertain etiology who would require, in the opinion of the referring physician, a liver biopsy as well as other studies to help establish the specific diagnosis. Those patients with long-standing hyperbilirubinemia or abnormal serum enzyme levels (SGOT, etc.) would be of particular interest.

Patients who are accepted for this study will be admitted to the Clinical Center for approximately two weeks and should anticipate having a liver biopsy performed.

Physicians interested in having their patients considered for the study may write or telephone:—MATTHEW MENKEN, M.D., Clinical Center, Room 4-N-117, National Institutes of Health, Bethesda, Maryland 20014. Telephone: 656–4000, Ext. 65955, (Area code 301).

BROCHURE—NEW DRUG ABUSE LAW

The American Pharmaceutical Association has prepared a brochure for pharmacists and other health practitioners outlining the requirements of the new federal drug abuse control law.

Entitled "HR 2 AND YOU", the brochure presents highlights of the Drug Abuse Control Amendments of 1965 as they affect health practitioners. It is designed to inform those who must practice under the new law as to the requirements established and to acquaint them with their individual responsibilities.

Single copies of "HR 2 AND YOU" are available free from APhA, 2215 Constitution Avenue, N. W., Washington, D.C. 20037. Quantity prices are: 25 copies, $2.50; 50 copies, $4; 100 copies, $6; 500 copies $20; 1,000 copies $35. Orders under $10 should be accompanied by check.

Antacid Therapy

By J. F. MORRISSEY, M.D. and
GIUSEPPE PERNA, M.D.
Madison, Wisconsin

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

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University of Wisconsin Medical School

■ FOR MOST OF THIS century antacids have been the keystone of the treatment of peptic ulcerative disease, a position merited by both theoretical and empirical considerations. Although there is considerable controversy surrounding many of the factors, known and unknown, which seem to be involved in ulcer pathogenesis, the central role played by hydrochloric acid and pepsin in ulcer formation is generally accepted.

Palmer and Nutter[1] were unable to find a case of persistent achlorhydria in 2,200 cases of proven peptic ulcer of the stomach and duodenum. Grossman[2] has also confirmed this principle stating that, "gastric acid secretion is required for the formation and persistence of the lesions and persons whose stomachs do not secrete acid do not develop duodenal ulcers."

Many animal observations indicate that the sole effect of acid is to activate pepsinogens, a pH of less than 3.5 being required for this effect. These observations on the significance of hydrochloric acid secretion suggest that if an antacid preparation could maintain the gastric acidity at a pH above 3.5, peptic activity would cease and ulcer healing would take place.

Although there are no rigidly controlled studies of ulcer healing reported which would confirm this hypothesis, the almost universal relief of ulcer symptoms by the ingestion of antacids provides strong supporting evidence of the truth of this concept.

Most commercial antacid preparations are mixtures of a variety of aluminum, calcium, and magnesium salts. The pharmaceutical manufacturers attempt to provide the physician with effective preparations which are palatable, relatively inexpensive, and free from harmful side effects. The undesirable effects on the body's acid-base balance produced by the regular use of extremely soluble antacids, such as sodium bicarbonate, has led to the use of less soluble preparations, particularly the aluminum hydroxide gels. The physical state of these compounds greatly affects their solubility and therefore is critical to their effectiveness.

Antacids must act within minutes in order to be effective because of the rapidity of gastric emptying in most patients. Grossman[2] has shown that 4 gm of calcium carbonate has the capacity to neutralize 80 mEq of hydrochloric acid, a quantity of acid which the average duodenal ulcer patient would require 27 hours to secrete. *In vivo* testing of this dose of antacid revealed an effective action lasting 40 minutes.

In general, the commercial *liquid* antacids have the needed speed of action. Tablet preparations which are high in the relatively soluble calcium and magnesium salts are effective in *in-vitro* tests, whereas those containing only aluminum hydroxide and magnesium trisilicate are relatively ineffective. These conclusions are based on observations made *in vitro* in our laboratory by observing the capacity of a standard dose of antacid to neutralize 10 mEq of hydrochloric acid within 5 minutes to a pH above 3.5. Using this test 90 ml of milk or half-and-half will not raise the pH above 2.8. For this reason we do not use milk or half-and-half in the treatment of ulcer patients.

Palatability is highest with the calcium drugs and least when the magnesium content is high. Because of "flavor fatigue" we usually recommend a variety of antacid preparations to our patients. In general our patients use tablet preparations during working hours and liquid preparations at home.

It is important for the physician to acquaint himself with the cost of the antacid

Doctor Morrissey is Associate Professor of Medicine, and Doctor Perna is an Instructor in Medicine, University of Wisconsin Medical School.

preparations which he prescribes for his patients. The most useful drugs are not necessarily the most expensive and there is a 20-fold variation in cost from the highest to the lowest.

The most common side effect of antacid therapy is disturbance of the bowel habit. Aluminum and calcium compounds tend to constipate and magnesium-containing antacids are laxative. There is considerable variability in these effects from patient to patient and in the same patient from week to week with the result that therapy must be individualized and patients warned of these effects when therapy is started. In bleeding patients serious obstipation may occur with antacid therapy unless preparations with high magnesium content are used.

A more serious effect is seen with the use of calcium-containing preparations. Approximately 1 per cent of patients will develop hypercalcemia, almost always within the first two weeks of treatment. These reactions are readily reversible if therapy is promptly stopped. Symptoms of anorexia, nausea, vomiting, headache, lethargy, weakness, and abdominal pain may occur. The serum calcium is regularly elevated as is the blood urea nitrogen. The urine calcium is not elevated. The serum calcium should be measured before and after two weeks of therapy to detect this syndrome before symptoms appear.

Recently, the hazard of high dose therapy with magnesium antacids in elderly patients with poor renal function has been recognized.[3] As serum magnesium rose a sequence of symptoms developed, starting with nausea, vomiting, and malaise, leading to hypotension, hyporeflexia, ataxia, decreased respiration, and electrocardiographic changes, and finally to carotid sinus sensitivity and sudden death. The fatal reactions occurred only in patients with definite renal failure.

Most of the commercial antacids contain approximately 1.0 mg of sodium per milliliter of antacid. On high dose therapy several hundred milligrams of sodium might be ingested each day, a quantity which would present a problem in a cardiac patient on a restricted sodium diet. The use of a mixture of sodium-free calcium carbonate and magnesium carbonate is suggested for such patients.

Dosage schedules recommended by drug manufacturers provide too little antacid too infrequently. Grossman[2] recommends 30 ml dosages of liquid preparations and 2 to 4 tablets of tablet drugs. He gives calcium carbonate powder in 2 to 4 gm dosages. We have observed in *in-vitro* testing no difference between such dosage levels and dosages approximately half as large. Gastric emptying rate appears to be independent of dosage so that the duration of antacid effect is not increased by giving a larger dose. On the other hand, reducing the dosage can increase patient acceptability and reduce cost and potential side effects. We favor 15 ml of liquid preparations or 2 tablets of tablet drugs.

Gastric emptying of antacids is complete in one hour in most patients, based on our observations[4] and those of others.[2] Schedules of administration more frequently than hourly are somewhat impractical and therefore are reserved for the most severely ill patients. Our recommendation, then, is hourly therapy with an effective preparation omitting the meal hour and the hours of sleep. In the occasional severely ill or bleeding patient, therapy may be continued throughout the night. Intensive therapy is continued for three months following the recommendations of Grossman[2] regardless of radiographic evidence of ulcer healing. We have followed a number of gastric ulcer patients with monthly gastroscopic and gastrocamera examinations and have been impressed with the delay between roentgen healing and complete epithelialization of the crater based on these endoscopic observations. Although a full meal provides a neutralizing effect sufficient to permit the omission of one dose of antacid, a snack, such as a small glass of milk, is ineffective and must be supplemented with an antacid dose. Because of their strong stimulating effect on hydrochloric acid secretion, coffee, tea, and alcohol are completely interdicted during the active phase of ulceration. Following ulcer healing patients are urged to use antacid coverage when these substances are ingested.

After three months of therapy, if complete ulcer healing has been documented, the antacids may be discontinued or the frequency of administration reduced to one hour after meals and at bed time. There are no well documented studies of antacid therapy which justify a recommendation of therapy beyond three months for most patients. We have, however, tended to recommend the prolonged use of antacids in reduced dosage for patients with severe or recurrent ulceration and for silent bleeders and we have sug-

gested to all our patients that they use antacids during periods of psychologic stress. We emphasize to all our patients the importance of taking antacids on a prescribed schedule for three months or longer, telling them that pain relief will occur within a few days but that ulcer healing requires weeks to months.

1300 University Avenue (53706).

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RESPONSIBILITIES OF THE BASIC SCIENCES TO MEDICINE

Under the above title, Dr. Philip P. Cohen, former acting dean of the University of Wisconsin Medical School, Madison, is the author of an article in the August 16 issue of JAMA. Doctor Cohen received both his M.D. and Ph.D. from the University of Wisconsin, where he is now professor and chairman of the Medical School's Department of Physiological Chemistry.

If medicine is to continue its dedication to becoming a scientific discipline, Doctor Cohen observes, it must be prepared to incorporate all scientific advances made in the basic areas of biology, chemistry, physics, etc., as they apply to man. The only reason this topic is a recurrent one, Doctor Cohen says, "is that the dedication of medicine to become a scientific discipline has posed some serious problems in the present setting. These problems stem of course from the fact that we have seen an explosion of scientific knowledge during the past two decades in particular which has been . . . overwhelming in its threat of obsolescence to the physician unprepared for its impact."

The boundaries which earlier clearly demarcated the various scientific disciples from one another no longer exist, Doctor Cohen points out, "largely because of the recognition that there is now a molecular or biochemical level of comprehension and concept common to all of these areas but which originally had a cellular, organismic, or some other basis for distinction. The advances made in biochemistry in particular have led to exciting new advances in the fields of subcellular anatomy, microbiology (and in particular, virology), physiology, immunology, pathology, pharmacology and genetics. In the area of genetics the biochemical knowledge of deoxyrihonucleic acid and ribonucleic acid has opened up scientific vistas unforeseen and still to be fully appreciated and exploited. In the area of pharmacology the development of 'tailor-made' drugs hased on biochemical knowledge has been a boon to therapy on the one hand and a bane on the other because of the rash of new drugs and their potency as iatrogenic agents when administered by physicians inadequately trained in modern science.

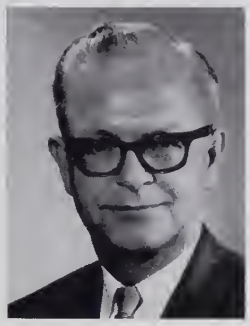
"Modern pathology reveals an increasing number of instances of a biochemical or molecular basis for understanding disease which is displacing the Virchow cellular concept of disease. The role of enzymes, hormones, and other biochemical factors in regulation of growth, differentiation, etc., are beginning to be understood and to be used as diagnostic and prognostic indices of disease."

In view of these considerations and others, Doctor Cohen says that the basic sciences have as their main responsibility "the challenge of exposing the medical student to all the *implications* of new and promising developments, not in detail, but in principle and concept. Obviously the implications of these new developments are of the greatest importance and must be presented in addition to, or in place of, the more traditional areas of knowledge. The *application* of both traditional and new knowledge must continue to be the responsibility of the clinician since he alone can select and apply the scientific principles appropriate for any given clinical situation."

The "gaps" which appear in consequence of the above position Doctor Cohen enumerates as "(1) the gap between the student's views of disease as developed in the implications of new advances and the traditional views of disease as represented by a clinician whose knowledge is based only on the past; (2) the gap between levels of concept and laboratory practice of the basic scientist and the academic clinician; and (3) the gap between the academic clinician and the practitioner out in the community away from a modern medical center.

"In essence, then," Doctor Cohen concludes, "the responsibility of the basic scientists is to prepare the student with an approach to his clinical years which permits him to challenge old ideas and practices with new concepts but which, hopefully, have been acquired from the basic sciences in a manner which allows for critical and rational judgment."

THE PRESIDENT'S PAGE . . .



J. H. HOUGHTON, M.D.
Wisconsin Dells

Which Way Shall We Go?

■ ATTENDANCE AT THE recent special meeting of the AMA House of Delegates in Chicago on October 2 and 3 provoked many thoughts and convictions. One impression was that all doctors thoroughly dislike Medicare and consider it to be but an omen of things to come. Opinion was unanimous that administration of this program will be difficult and beset with confusion for all concerned. Some doctors are determined not to participate. There were diverse opinions, but this observer was struck with the sincerity of all concerned. Without being said in so many words, it was apparently the consensus of all physicians that the fight against this type of legislation must continue. How best to do this was not decided nor even discussed at any great length, except for those who urged nonparticipation.

In guiding our judgment on these serious matters, certain facts must be kept in mind, and the opinions expressed are those of the writer, not necessarily those of the State Medical Society of Wisconsin.

1. Medicare is the law of the land.
2. Our present Federal legislation is controlled by Labor.
3. Labor is on record in some of its publications as wanting extension of Medicare to other age groups with eventual complete socialization of Medicine in this country. By Labor I mean the leaders, not necessarily the rank and file worker.

Admitting the above statements, it follows that nothing we as a group or as individuals can do or say will influence the majority of our present legislators. Our only recourse is at the polls. This means political activity at the grass roots level to educate and influence our citizens to elect legislators to represent all the people and not just one powerful segment of them. I am *not* convinced that the people want Medicare. I am convinced that Labor wants it.

Medicine can not do this alone, but I am sure there are many people, many professions, and many trades who feel as we do, if they would only stop to think about it, and expend the time and effort to become informed about what is really going on.

The AMA has been criticized for not doing enough to forestall Medicare. The AMA did all that was humanly possible. We did not lose the battle in July of 1965. We lost it in November of 1964, and the AMA did not lose it. The medical profession and all the people who believe in free enterprise lost it, because they lacked the knowledge and the foresight to realize what was happening to them, and what to do about it.

In my humble opinion, Medicine still has a great opportunity to mobilize public opinion by launching an offensive against the Welfare State. How to go about reversing this trend? By embarking on an educational campaign to properly inform every citizen about where we are going in terms of cost and loss of individual freedom. As I said before, Medicine can't do this alone, but I'm sure if

we lead the way others will follow. This must be done not only for the next elections but also on a continuing basis, if we are to safeguard our traditional freedoms and reverse this socialistic trend.

This means work and I don't mean just by the AMA. I mean work by every physician in his own community. He must be active politically. He must talk to local groups, to local service clubs and he must be informed and factual. He must know which candidates are for free enterprise and he must actively support them and influence others to support them. This is not a partisan issue. It matters not whether the candidate be a Democrat or a Republican. What does matter is whether he believes that free enterprise must be preserved. I am convinced that we still have time but very little. If we really go to work I am convinced that we can preserve our American way of life.

If we don't, I am just as certain that we will be surrendering to the social planners, and we will have to resign ourselves to complete government control of everything.

Which way shall we go?

J. H. Houghton, M.D.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

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Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

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Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

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While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

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The Emerging Citadel

■ FOR YEARS MANY doctors have had strong misgivings about the real objectives of the American Hospital Association. Representatives of the AHA have always denied that their purposes were anything but the preservation of the system that has furnished high quality, effective health care to the American people. Now, however, the dissimulation has ended, and the hospital administrators have clearly stated their ambition to control every facet of medical service available to the public.

A *Statement on the Changing Hospital and the American Hospital Association,* recently adopted by the AHA, spells out the master goal of the organization. No longer is the hospital to be a facility for the care and treatment of the sick by physicians and surgeons. In the AHA vision, the hospital is the "citadel of medical services in modern society." It is to be "an organized arrangement of all medical resources necessary to bring the individual, wherever located, into contact with the skills of his physician and other members of the health care team." It is to be the health care instrumentality of the community (read government), the exclusive source of all medical service to the individual. It is even to embrace with its tentacles such non-hospital functions as school health programs, visiting nurse services and other preventative, curative, and rehabilitative health services. The entire spectrum of health care—the richly developed, highly refined expression of the finest ideals of an enlightened, altruistic society—is now to be made the power tool of the hospital administrator.

To be sure, the *Statement* recommends that the physician be "increasingly involved in the organizational workings of the hospital." Taking its simile from another area of make-believe, the AHA believes that doctors must be given "the opportunity and the responsibility to help write the organizational script as well as act from it." But presumably the hospital administrator will direct and produce the drama as well as sit in the box-office and sell the tickets of admission. Doctors will no longer retain their professional independence nor their integrity; under the AHA

plan they will be "involved" in the "citadel." As individuals, they will be subordinate to the organization which has subsumed all health care functions.

Make no mistake about it, the issue is control of the medical profession. At stake is not only the freedom of individual practice but also the continued control of health care services by qualified medical personnel rather than administrators.

After many years of paying lip service to the cause of free medical practice, the AHA has openly joined the ranks of those who would extend federal control over every facet of health care. In its *Statement* the AHA claims to recognize that most health care is paid for either by insurance companies or the government, who are sophisticated "purchasers" of service, "not merely passive payers for services. They are properly insistent upon prudent management of hospitals and upon guarantees that the available health resources of all kinds—money, people and facilities—be used efficiently and effectively." And who is to see to it that the available health resources are used efficiently and effectively, according to the desires of the highly sophisticated "purchasers?" Why, the hospital administrators—that's who. And so the knot is tied and the health care package is delivered, gift-wrapped and be-ribboned, to the federal bureaucrats by the hospital administrators.

Chilling as it is to contemplate, the scheme is unfortunately a logical conclusion of present trends. For reasons of convenience, many doctors have abdicated their responsibilities to the hospitals with which they are associated. They have permitted hospitals to assume an unwarranted importance in their own practices; they have often made heavier use of hospital facilities than necessary. If doctors are to preserve their independence as scientists and practitioners, we must make an energetic, planned effort to retain control of our medical activities. We must refrain from seeing patients in hospitals when they can be seen in our own offices at less cost and greater convenience to the patient. We must make greater use of non-hospital laboratory facilities when available, often at less cost to the patient. And we must not submit to any effort to reduce us to the status of pawns under the direction of a hospital administrator.

Before the hospital administrator becomes entrenched in his "citadel," local medical societies must take a firm position against any implementation of the AHA plan for capturing the national medical environment. Vigilance, foresight, and concerted action on the part of organized medicine is required, and the battle must be fought and won on a community level. Now that the AHA has defined its position, the medical profession knows where the danger lies. We must overcome it vigorously. If we back off this time, we lose our professional independence. —D.N.G.

Keeping Pace

DR. THOMAS C. MEYER, Assistant Dean and Director of Postgraduate Medical Education at the University of Wisconsin Medical Center, has a bundle of valuable and refreshingly up-to-date programs for the continuing education of the physicians in the state of Wisconsin. News of his plans is an encouraging sign that the University of Wisconsin is rising to its responsibility to offer the means of extending the education of practicing doctors in the state.

Happily, the pace of postgraduate medical education is accelerating in many medical schools. The trail-blazing done by the American Academy of General Practice in the field of practitioner education has unquestionably opened the way to many similar programs for doctors. When the AAGP required, as a condition of membership, that the doctor attend a minimum of 150 hours of high-caliber lectures each three years, it underlined the necessity for serious, programmed education for practicing physicians, and responsible institutions of medical learning were not slow to follow suit.

Doctor Meyer's courses are of a quality acceptable for AAGP accreditation. In addition, he makes use of modern technologies of communication that permit the busy doctor to attend lecture courses without leaving his home town. The telephone conference program offers a 24-week course via telephonic conference calls and sets of duplicate slides at a savings of time, money, and effort to both the lecturer and the audience.

The *In Depth* course at the University of Wisconsin, featuring recent developments in the management of elderly patients, as well as the special conferences in Madison and in Milwaukee, offer the doctor a fine oppor-

tunity to improve his practice by keeping pace with the expanding perimeter of medical science. Marquette University, the State Medical Society, and others, too, are cooperating.

In his use of modern techniques of communication and the latest developments in audio-visual education, Doctor Meyer is making a significant contribution to the continuing education of Wisconsin's doctors. His enthusiasm and his vigorous approach to the problem have earned the respect of those concerned with the state of postgraduate education. His enterprise merits applause, but more important, his courses deserve the attendance and support of all medical personnel. —D.N.G.

EDITOR'S NOTE: A detailed announcement of the 1965–1966 telephone conferences appears at the back of this issue, at page 62, together with a list of the curriculum, faculty, and registration form. A listing of postgraduate programs will be a regular monthly feature of the JOURNAL.

Medical Student Attrition

DESPITE THE GREATER complexity of the work and the longer time it takes to acquire a medical degree, far fewer students drop out of medical school than out of any other program of higher education. Figures published recently by the Association of American Medical Colleges indicate that only 9 per cent of the students starting medical education in the years between 1949 and 1958 failed to graduate, while 43 per cent of those starting law school and 40 per cent of those starting other college courses dropped out before completion.

Of the 9 per cent who left medical schools before receiving their degrees, over 5 per cent did so because of academic difficulties. The remainder, less than 4 per cent, dropped out for reasons of emotional difficulties, insufficient motivation or financial problems.

The low drop-out rate in medicine is gratifying in view of the enormous costs of training medical personnel. But it also speaks well for the screening and selection programs of American medical schools. It reflects the sincerity and motivating idealism of the young people who consider medicine as a career, as well as their intelligence and capacity for hard work.

In addition, the amazingly few students who drop out for financial reasons undoubtedly reflects the activity of organizations such as the State Medical Society of Wisconsin's Charitable, Educational and Scientific Foundation, which maintains a very active student loan fund.

Here's another powerful reason to contribute to the *CES Foundation* regularly and generously. —D.N.G.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Minutes of Council Meeting

MADISON, AUGUST 1, 1965

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 9:30 a.m. at the Offices of the State Medical Society on Sunday, Aug. 1, 1965.

Voting members present were: Doctors James, Nordby, Davis, Stoops, Carey, Blanchard, Kief, Fox, Boren, Ludwig, Manz, Ekblad, Lee, Houghton, Van Hecke, Wright, Past President Curran, President Houghton and Speaker Callan.

Voting members absent were: Doctors Schulz, Nadeau, Chojnacki and Hollenbeck.

Others present were: President-Elect Drew; AMA Delegate, Doctor Galasinski; AMA Trustee, Dr. L. O. Simenstad; Messrs. Crownhart, Koenig, Ragatz, Brower, White, Kluwin, Gill, Murphy, Maroney and W. J. Brown, AMA Field Representative; Mrs. Anderson.

2. Approval of Minutes—May 2 and May 5, 1965

On motion of Doctors Ekblad–James, carried, the minutes of the Council meetings of May 2 and May 5 were approved as distributed. (Printed in September issue of WISCONSIN MEDICAL JOURNAL.)

3. 1966 Wisconsin Work Week of Health—125th Anniversary Year

The preliminary program for the 1966 Wisconsin Work Week of Health was reviewed by Mr. Koenig. The material discussed included programs on:

(a) The Future of Drives to Eliminate Quackery
(b) Medicine Today; What Will It Be Tomorrow?
(c) The Role of Official and Voluntary Health Agencies Today and in the Future
(d) Occupational Health Today and in the Future
(e) Government Participation in the Health Care Field
(f) Mental Health, Drug Addiction, etc.

Chairman Fox asked that each Councilor review the program and make suggestions for specific topics to be considered, as well as speakers for the various subjects.

4. Fall House of Delegates Date

Because of other conflicting meeting dates and since the Wisconsin Legislature reconvenes on October 4, the Interim Session of the House of Delegates was called for Saturday, October 9.

It was further felt that the Interim Session would not involve more than one day, that the reports and budget material be sent as early as possible to the Delegates and that the staff so plan.

It was moved, seconded, Doctors Van Hecke–Blanchard, carried, that the House of Delegates meet for a one-day session on October 9 and that the Council meet on Friday, October 8.

5. Association of the Professions

A proposed constitution and bylaws requested by the Executive Committee of the Council, and attached to the agenda, was considered. Also considered was the present position of other professional associations in Wisconsin on an organization such as the one proposed.

It was moved, seconded, Doctors Houghton–Nordby, carried, that the State Medical Society of Wisconsin proceed with organizing the Wisconsin association of the professions.

6. American Medical Association Annual Convention—June, 1965

AMA Delegate Galasinski reviewed the actions of the AMA House of Delegates meeting in New York.

He stated that federal health care legislation, the report of the president's Commission on Heart Disease, Cancer and Stroke, the Gundersen Committee report on the organization of the House of Delegates, and a plan for a new method of establishing AMA scientific sections were among the major subjects acted upon by the House of Delegates of the AMA in June of 1965.

Component medical societies were urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives and other interested parties for the purpose of exchanging information and for the de-

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velopment of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care. These recommendations are to be reported to the Board of Trustees of the AMA.

A list of actions was contained in the agenda.

7. Status of National Legislation

A. The passage of H.R. 6675 was discussed and it was recommended that a statement be issued regarding the position of the State Medical Society on this law.

It was moved, seconded, Doctors Van Hecke–James, carried, that a committee be formed to write a statement for public release concerning the position of the physician membership of the Society, represented by the Council, on recent health care legislation and that the committee consist of the President, President-Elect, Chairman and Vice-Chairman of the Council. (Printed in Supplement to September issue of WISCONSIN MEDICAL JOURNAL.)

B. The Council considered the DeBakey report and the actions of the Deans of Marquette Medical School and the University of Wisconsin Medical School in requesting participation in these programs.

It was moved, seconded, Doctors Nordby–Blanchard, carried, that the Commission on Hospital Relations and Medical Education consider the proposed legislation of the President's Commission on Heart Disease, Cancer and Stroke and that CHRME meet with Doctor Eichman, Dean of the University of Wisconsin Medical School, and Doctor Hirschboeck, Vice-President of Marquette University Medical School.

THE OATH OF OFFICE OF THE STATE MEDICAL SOCIETY OF WISCONSIN WAS ADMINISTERED BY CHAIRMAN FOX TO COUNCILOR CAREY OF THE FOURTH COUNCILOR DISTRICT

---

8. The 1965 Wisconsin Legislative Session

Mr. Murphy reported on the actions of the 1965 legislature to date and stated that the Council and House of Delegates will receive a detailed report on the status of all legislation of immediate concern to the Society. At the present time the Society is following approximately 175 bills which are categorized as

(a) action bills,
(b) watch bills, and
(c) informational bills.

Public appearances have been made on 25 major items of legislation and the Society has supported 20 of the 25 proposals.

The actual practices of the limited licensees needs careful review as contrasted with the practices as defined by law according to the report made to the Council.

9. Limited Licensees

The Council discussed the problem of the limited licensee and the suggestion that the medical schools be asked to review the status of some of these matters as to whether they should or should not be incorporated within the schools of medicine in the state.

It was moved, seconded, Doctors W. J. Houghton–Kief, carried, that the Commission on Public Policy meet with representatives of the University of Wisconsin Medical School to consider the problems presented by the training and actual practices of those possessing a limited license.

10. Medical School Liaison

A. Plans for a Dean's Reception—A reception is being planned for September 19 for Doctor Eichman, the new Dean of the University of Wisconsin Medical School.

B. It was agreed that the Deans of the medical schools be invited to meet with the Council next fall to discuss long range planning for medical education.

11. Reports by Consultants

A. Mr. Kluwin, Associate General Counsel, summarized some of the problems that he felt needed the consideration of the Society. Among those discussed were the threat to the right of the physician to practice privately and the need for better public relations in such matters as house calls, isolated practice in an office behind a nurse or other employee and the refusal to participate in court proceedings—these all need the attention of all physicians.

Mr. Murphy, General Counsel, stated that his firm has represented the State Medical Society and all of its divisions and corporate entities in fields such as taxation, insurance, retirement funds and the problems relating to operating a realty corporation and a charitable, educational and scientific foundation.

The Society was also represented in the legislative forum, both federal and state, and problems in forensic medicine that provide answers of benefit to the entire membership of the organization rather than those of specific interest to one member were dealt with by the offices of the general counsel.

B. Mr. Gill, Accounting Consultant, outlined three aspects of his firm's work stating that they audit all divisions of the State Medical Society, report to the House of Delegates and prepare reports required by various agencies of the government such as the Internal Revenue Bureau and the Insurance Department.

Mr. Gill reported that his firm has also advised on specific projects assigned by management and staff during the past year and that the firm had received the complete and unrestricted cooperation of the management and staff of the Society.

12. Commission on Scientific Medicine

Mr. Ragatz gave a progress report on the scientific program for the 1966 Annual Meeting to be held in La Crosse. Speakers as well as specific topics were considered by the Council.

New activities of the University of Wisconsin Medical School in the area of postgraduate medical education were reported as were other areas of scientific teaching programs sponsored by the Society.

The program of the Northwest Psychiatric Clinic being sponsored by the Division on Nervous and Mental Diseases (fiscal note: $100.00 plus travel expenses for one speaker) and the three programs to be sponsored by the Division on Maternal and Child Welfare on maternal mortality and infant identification were reviewed by the Council.

It was moved, seconded, Doctors Nordby–Carey, carried, that the programs of these Divisions be approved as presented.

13. Commission on State Departments

A. *Chairman for the Division on Safe Transportation*

Doctors Blanchard–Manz nominated J. L. Weygandt, M.D. for the position of Chairman of the Division on Safe Transportation.

It was moved, seconded, Doctors Nordby–W. J. Houghton, carried, that the nominations be closed and that the Secretary be instructed to cast a unanimous ballot for Doctor Weygandt.

B. The Council agreed that the Executive Committee of the Council should review reports from the Commission on State Departments being prepared for the House of Delegates.

C. The recommendation by the Legislative Committee to Visit State Institutions that the services of the Diagnostic Center in Madison be phased out was reviewed by the Council.

It was moved, seconded, Doctors Kief–James, carried, that the Chairman of the Commission on State Departments be asked to issue a statement of the concern of the State Medical Society over the proposed phasing out of the Diagnostic Center and that the Commission study the problems presented in the recommendation from the Committee to Visit State Institutions.

14. The Council Nominated H. A. Sincock, M.D. to Serve on the State Board of Health Advisory Hospital Council

15. Miscellaneous

A. A statement from PR DOCTOR congratulating Dr. H. Kent Tenney, Jr. on his outstanding efforts on behalf of the public relations of physicians and his work for the benefit of public health was presented.

It was moved, seconded, Doctors Ekblad–Stoops, carried, that the Council forward its congratulations and appreciation to Doctor Tenney and that this be spread upon its minutes and printed in the WISCONSIN MEDICAL JOURNAL. (Printed in September issue.)

B. A resolution congratulating Michigan State Medical Society in its 100th year of organization was presented and the Council unanimously adopted the resolution. (Printed in August issue of WISCONSIN MEDICAL JOURNAL.)

C. The Council encouraged Doctor Drew and the Milwaukee County Medical Society to make arrangements for a special train to bring Milwaukee physicians and their families to the 1966 Annual Meeting in La Crosse.

The Council adjourned at 12:20 p.m.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

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Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

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4. Doe, J. E.: What I know about it,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

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NOVEMBER 1965

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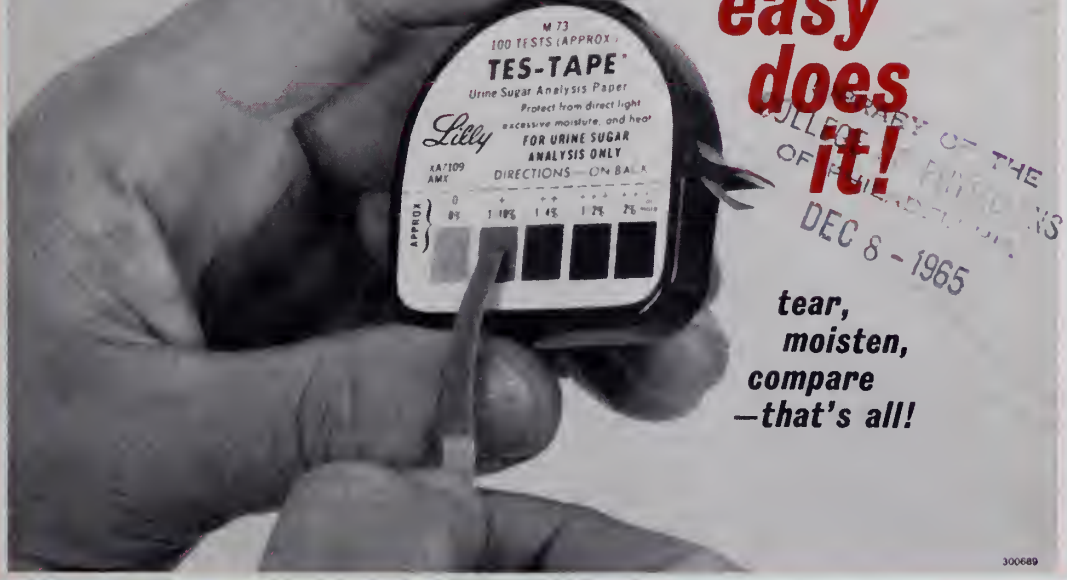

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"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959

COUNTY SOCIETY PROCEEDINGS

BROWN

The October meeting of the Brown County Medical Society was held October 14 at the Northland Hotel. Following a business meeting and dinner, *Dr. Thomas Meyer*, pediatric cardiologist at the University Hospitals and assistant dean of the UW Medical Center, spoke to the group.

DODGE

A golf and business meeting were combined for the first fall meeting of the Dodge County Medical Society on September 22. Golf during the afternoon was arranged by *Dr. Michael Bachhuber* at the Mayville Golf Club. After dinner a business meeting was conducted, principally around correspondence received. Guest for the evening was Mr. Lawrence (Budd) Ryder, field service representative of the State Medical Society. He answered numerous questions pertaining to health insurance and medicare legislation. *Dr. L. W. Schrank*, Waupun, delegate to the Interim Session of the SMS House of Delegates which met October 9 in Madison, gave a report of that meeting.

EAU CLAIRE–DUNN–PEPIN

The Eau Claire–Dunn–Pepin County Medical Society sponsored a Tenth Councilor District meeting September 23 in Eau Claire. *Dr. Peter L. Eichman*, Madison, new dean of the University of Wisconsin Medical School, spoke on aims and progress of the school. Four Eau Claire physicians discussed medical problems relating to major trauma during the afternoon session at the Eau Claire Country Club. Speakers and their subjects were *Drs. J. B. Dibble*, "Severe Burns;" J. W. Merritt, "Major Trauma to the Thorax;" *Ralph F. Hudson*, "Major Trauma to the Abdomen;" and *Walter M. Kelley*, "Airway Problems in Head and Neck Trauma." The new councilor for the district, *Dr. Walton R. Manz*, Eau Claire, was introduced.

FOND DU LAC

Dr. William G. Kendell was elected president of the Fond du Lac County Medical Society during a meeting at Fond du Lac, September 23. He succeeds *Dr. Howard Mauthe. Dr. Russell Pelton* of Ripon was named vice-president, and *Dr. John G. Parrish* was reelected secretary–treasurer. *Dr. David J. Twohig, Jr.* was renamed a delegate to the State Medical Society and *Dr. James Sisk* was reelected alternate delegate. Doctor Mauthe was appointed censor.

New members received into the local organization were Dr. Howard Theis and *Dr. F. Fuller McBride* who are practicing obstetrics and gynecology; Dr. Charles Longstreth, anesthesia, and *Dr. Robert Carlovsky*, a pathologist at St. Agnes Hospital. Doctor Carlovsky, a native of Fond du Lac, took his residency work in Denver, Colo.

During the meeting Doctor Twohig reported on the recent decisions of the Council of the State Medical Society and *Dr. H. J. Kief* gave a report concerning activities of the Council of the American Medical Association.

GREEN LAKE–WAUSHARA

Twenty-one members were present September 30 at the Whiting Hotel in Berlin for the meeting of the Green Lake–Waushara County Medical Society. The business session centered around plans for Community Health Week. Speakers for the evening were veterinarians, Drs. Fred Wells and N. W. Klepinger of Berlin. Their subject was "Commonly Used Farm Poisons," which stressed the potential dangers to humans from the chemicals commonly used on the farm.

LA CROSSE

The La Crosse County Medical Society held a day-long symposium on diseases of the thyroid November 3 at the Holiday Inn and Holiday Lanes. During the morning session speakers and their topics included: Dr. Solomon Silver, assistant clinical professor of medicine, Columbia University College of Physicians and Surgeons, on diagnostic methods in thyroid disease; Dr. Oliver Cope, associate professor of surgery, Harvard University Medical School, on management of thyroid carcinoma.

Dr. Oliver H. Beahrs, head of the division of surgery, Mayo Clinic, Rochester, on solitary thyroid nodule; and Dr. George Bray, Endocrine Department, Pratt Clinic, New England Center Hospital, on pathogenesis and treatment of nontoxic goiter. *Dr. David L. Morris* was moderator.

Dr. Loran F. Pilling, psychiatric consultant, Mayo Clinic, spoke on "How Good is the American Family" during the luncheon which was attended by both physicians and their wives.

The afternoon program featured Doctor Silver again on thyroiditis, and a panel discussion by all of the four speakers on "Medical vs. Surgical Treatment of Graves' Disease."

RACINE

The October dinner meeting of the Racine County Medical Society was held on the twenty-first at Wingspread, Johnson Foundation. The program included a J. I. Case movie on High School Drop-out

---

Physicians whose names appear in italics are members of the State Medical Society.

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COUNTY SOCIETIES *continued*

Problem. Dr. Robert Dugger, corporate vice-president and industrial relations director of the J. I. Case Company, was the speaker.

RICHLAND

On October 7 ten members of the Richland County Medical Society met at Richland Center to hear *Dr. Charles Reed* of the University of Wisconsin Department of Allergy talk on Allergy in Disease.

TREMPEALEAU–JACKSON–BUFFALO

The Tri-County Medical Society met October 26 at the Castle Hill Supper Club near Black River Falls. *Dr. George Miller* of Eau Claire spoke on recent developments in the field of ophthalmology.

WAUKESHA

The Waukesha County Medical Society and its Auxiliary met October 6 at the Waukesha County Hospital. Following dinner a program to familiarize physicians with the hospital proper and with the facilities now available for county residents was presented by *Dr. Chester Wade* in cooperation with Mr. Emery Reuss, superintendent of the institution. Business meetings of the Medical Society and the Auxiliary completed the evening.

WINNEBAGO

Winnebago County Medical Society members heard a talk on "New Drugs in Gynecology" at the September 30 meeting held in Oshkosh. Speaker was Dr. Maxwell M. Barr, Minneapolis.

WOOD

Forty-two members and 12 guests were present for the September 9 meeting of the Wood County Medical Society held at the Twilite Motel in Marshfield. Guest speakers were Mr. P. R. Smith and Mr. DeWitt Bowman of the First National Bank of Madison. Their subject was on trusts and investments.

During the business session the subject of redistricting of councilor districts was discussed with no action taken. Two Wood County osteopathic physicians were given certification for postgraduate training. The group was informed about Project Viet Nam. Information was presented on the AMA venereal disease program. Participation in Community Health Week, November 14–21, was recommended and referred to a planning committee. An AMA report on how the Sherman Anti-Trust Law affects organized groups was presented.

SPECIALTY SOCIETY PROCEEDINGS

Sheboygan Unit, WHA

The value to the cardiac stroke victim of early therapy by trained personnel was stressed during a seminar for professional nurses September 30 in Sheboygan. This was the first of two such seminars to be held at St. Nicholas Hospital under the sponsorship of the Sheboygan County Heart Unit of the Wisconsin Heart Association.

The seminar, which centered on strokes and continuity of patient care, was attended by 135 registered and practical nurses.

Speakers included *Dr. Edwin C. Welsh*, director of rehabilitation at St. Luke's Hospital in Milwaukee and associate professor of physical medicine (rehabilitation) at Marquette University; and *Dr. Robert Senty*, president of the Sheboygan County Medical Society and board member of the WHA.

The second session of the seminar was held October 14. Doctor Senty was a member of a panel discussion at this meeting.

Brown County Division, WHA

A cardiac seminar for nurses was held during September and October at St. Vincent Hospital, Green Bay, sponsored by the Brown County Division of the Wisconsin Heart Association.

Dr. J. L. Bramschreiber, Green Bay, spoke on "The Cardiovascular System—Function and Dysfunction" at the first session held September 21. *Dr. J. H. Randall*, Green Bay, was the principal speaker at the second session held September 28. His topic was "Coronary Patient—Coronary Insufficiency and Myocardial Infarction."

A third session was held October 5. The fourth session featured "The Patient and the Nurse in Heart and Blood Vessel Conditions." *Dr. Robert E. Johnston*, Green Bay, was the featured speaker. He discussed hearts with irregular beats. The final session was held October 19.

Milwaukee Division, ACS

Dr. James E. Conley, Milwaukee, was elected president of the Milwaukee division of the American Cancer Society at its annual meeting October 6 at the Milwaukee Club. *Dr. L. J. Van Hecke*, Milwaukee, was elected for a one-year term as a vice-president. Other physicians elected to two-year terms on the division's board of directors are: *Dr. Wayne Boulanger*, Whitefish Bay; *Dr. George Flynn*, Milwaukee; *Dr. Joseph Kuzma*, Wauwatosa; and *Dr. Anthony Grueninger*, Milwaukee.

Wisconsin Radiological Society

The 16th annual meeting of the Wisconsin Radiological Society was held at Deer Park Lodge, Manitowish Waters, September 17–19. Guest speaker was Dr. M. Vera Peters from The Princess Margaret Hospital in Toronto, Ontario, Canada, whose subject was "The Scope of Radiotherapy in Hodgkin's Disease."

Other speakers were *Drs. James R. Nellen, Harold F. Ibach, Alan B. Fidler*, and Charles Lescrenier, all of Milwaukee, and *Drs. Richard L. Wesenberg* and *Andrew Crummy, Jr.*, Madison.

Dr. Eugene Betlach, Janesville, was elected president to succeed *Dr. Theodore J. Pfeffer*, Milwaukee. *Dr. Howard Mauthe*, Fond du Lac, is president-elect and *Dr. Charles Benkendorf*, Green Bay, was named vice-president. Doctor Ibach was elected secretary–treasurer for the next three years. *Dr. Leslie E. Jones*, Fond du Lac, and *Dr. Wayne Rounds*, Madison, were elected to the board of directors and *Dr. Farrell Golden*, Madison, to the board of censors. *Dr. Robert Feulner*, Waukesha, was reelected councilor to the American College of Radiology for a three-year term, with Doctor Jones appointed as the alternate.

New members accepted into the society were *Drs. James E. Bell, Audrey Straka Huckaby, Albert Nemcek*, and *Matthew Elson*, all of Milwaukee; *Dr. Emil Schulz*, Eau Claire; *Dr. Michael Jacobi*, Manitowoc, and Doctors Crummy, *Stanley Wyner, John Borton Davis*, and *Stephen Dudiak*, all of Madison.

Program chairman was Doctor Nellen and registration chairman was Mrs. Agatha Mauthe.

Wisconsin Academy of General Practice

Dr. Howard M. Klopf, Milwaukee, took over the presidency of the Wisconsin Academy of General Practice at that organization's 17th annual scientific assembly and convention in September at Holiday Inn Central, Milwaukee. He succeeds *Dr. W. D. Hamlin*, Mineral Point, who was appointed chairman of the board of directors and alternate delegate to the AAGP.

Elected president-elect was *Dr. C. A. Grand*, Ashland, who is serving as vice-president this year. *Dr. T. J. Cox*, Whitefish Bay, was reelected secretary–treasurer. *Dr. G. J. Derus*, Madison, was elected speaker of the Congress of Delegates and *Dr. A. J. Sanfelippo* was elected vice-speaker.

September 19, at the opening of the assembly, the Congress of Delegates reaffirmed its opposition to establishment of a board of certification for general practitioners. Establishment of such a board was voted by the American Academy of General Practice at its national convention last April.

Speaking against the establishment of the board, *Dr. Robert F. Purtell*, Milwaukee, a past president of the Academy, said: "Status is not awarded." Doctor Hamlin observed that one of the reasons why the American Academy voted for establishment of the board was that "there are more general practitioners needed and certification would draw more

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Physicians whose names appear in italics are members of the State Medical Society.

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SPECIALTY SOCIETIES *continued*

young men into general practice." The controversy over certification, he said, revolves around the kind of postmedical school training a general practitioner would receive.

The American Academy specified that training would be required in internal medicine, psychiatry, pediatrics, rehabilitative medicine, and a certain amount of public health. Minor training would be given in surgery, orthopedics and obstetrics, Doctor Hamlin stated.

The general practitioner "should be a broadly trained man when he comes out," Doctor Hamlin said, and giving only minor training in the last three fields would not accomplish this.

Milwaukee Academy of Medicine

"Clues to Cardiac Diagnosis from Examination of Arterial and Venous Pulses" was the topic presented by Dr. Nobel O. Fowler at the October 19 meeting of the Milwaukee Academy of Medicine. Doctor Fowler is professor of medicine and director of the Cardiac Research Laboratory, University of Cincinnati College of Medicine.

Wisconsin Society of Internal Medicine

Two Madison physicians were installed as officers of the Wisconsin Society of Internal Medicine during the group's annual meeting October 15 in Madison. *Dr. A. A. Quisling* was installed as president and *Dr. Edward K. Ryder* was elected secretary–treasurer. Doctor Quisling succeeds *Dr. George E. Gutmann*, Janesville.

Dr. John H. Wishart, Eau Claire, was elected president-elect. *Dr. George R. Barry* and *Dr. John M. Irvin*, both of Monroe, were elected to the governing council. The meeting was attended by 134 physicians from 35 cities.

Pathologists–Medical Technologists Meet

The Fourth Joint Meeting of the Wisconsin Society of Pathologists and the Wisconsin Association of Medical Technologists was held in Milwaukee November 12–14. This year it coincided with the meeting of the North Central Region of the College of American Pathologists.

Six physicians participated in the program. Preconvention seminars on November 12 were presented by faculty members of Marquette University School of Medicine. *Dr. Robert A. Scheidt* conducted one on "Introduction to Advanced Instrumentation" while *Dr. Armand J. Quick* presented "Coagulation."

Papers presented at the November 13 session included Dr. Richard T. Kelly's "Rapid Indentification of Barbiturates by Thin Layer Chromatography" and *Dr. Daniel Collins'* "Thin Gel Electrophoresis; LDH Isoenzymes."

During the November 14 session, *Dr. Anthony V. Pisciotta* presented a paper on "The Pathogenesis of Drug-Induced Bone Marrow Damage. *Dr. Joseph F. Kuzma* presented one on "Laboratory Accidents, Their Prevention and Treatment."

NEWS OF WISCONSIN PHYSICIANS

Dr. Rankin on Visiting Faculty

When the Council on Postgraduate Medical Education and the Committee on Pulmonary Physiology of the American College of Chest Physicians presented its 20th annual postgraduate course, "Clinical Cardiopulmonary Physiology," October 18–22 in Chicago, one of the visiting faculty members was *Dr. John Rankin,* Oscar Rennebohm professor of medicine, Cardiopulmonary Laboratory, University of Wisconsin, Madison. His subject was "Granulomas of the Lung."

Chicago faculty included *Dr. Andrew L. Banyai,* clinical professor of medicine, emeritus, Marquette University.

Dr. Nereim on AAGP Board

Dr. Theodore J. Nereim, Madison, was recently elected to the board of directors of the American Academy of General Practice, an event which occasioned a full page writeup in the September issue of GP. Entitled "Second Wisconsinite to High Office," the article states that *Dr. William Hildebrand* of Menasha was Academy president in 1954–55. In a sketch of Doctor Nereim's background, the writer mentions his seven-year membership in the Congress of Delegates, his chairmanship of the Reference Committee on Education in 1964 and of the Committee on Awards in 1960 and 1961, and his service on the Committee on Constitution and By-Laws in 1964–1965. Doctor Nereim is now beginning a three-year term on the Commission on Education. His activities in the Wisconsin Chapter, including its presidency, his other activities both medical and civic, and his educational background are all recounted.

Wausau Doctors Named to Council

Drs. A. W. Hoessel and *R. B. Larsen* are among those who will serve on a health facilities planning council organized in September at Wausau. Representing the Marathon County Medical Society on the council is *Dr. J. V. Flannery.*

Group Hears Dr. Clauson

Dr. C. T. Clauson spoke on the subject of diabetes at a meeting of the Hospital Auxiliary September 9 in Bloomer.

Observes Stanley Physicians' Practice

Mary Cowles, Loyal, University of Wisconsin medical student, spent a week in September observing general practice with *Drs. R. J. Mathwig* and *A. W. Overgard* at the Stanley Clinic and Victory Memorial Hospital.

Dr. Karzel Heads Society

Dr. Ronald P. Karzel, Janesville, was elected president of the Rock County Cancer Society at a meeting held in September at Janesville. *Dr. R. J. Gray,* Evansville, was among the new directors elected at the meeting.

Chapter Hears Dr. Price

Dr. James Price, professor at the University of Wisconsin Medical School, Madison, described his work in cancer research as speaker for the annual dinner meeting of Eau Claire County Chapter, American Cancer Society, in September at Eau Claire.

Dr. Pizer Opens Oak Creek Office

After 11 years of association with the Fine and Lando Clinic, Cudahy, *Dr. Jerome A. Pizer* opened an office in Oak Creek in September. He expected to move from his temporary office around November 1 to new medical offices in the Oak Brook Shopping Center.

Dr. Chung at Racine

Dr. James C. M. Chung announced his association in September with *Dr. Richard J. Fogle* in the practice of ear, nose and throat surgery in Racine.

Dr. Sun to Wittenberg

Dr. Kwok Cheng Sun started a practice September 22 in Wittenberg, which had been without a physician for over a year. He announced at the time that his Wautoma office would be temporarily closed. He also practiced for a time at Siren.

Dr. Windeck Elected to AAGP

Dr. James L. Windeck, Chippewa Falls, has been elected to active membership in the American Academy of General Practice.

Dr. Bolger Announces Plans

Dr. James V. Bolger announced plans in September for expansion and remodeling of the Bolger Building in Waukesha. Also announced by Doctor Bolger was the addition to the staff, October 1, of Dr. Michael McCormick. The son of staff member *Dr. George L. McCormick,* he has just completed a residency in ophthalmology at the Illinois Eye and Ear Infirmary, Chicago. Others in the building are *Drs. J. Victor Bolger* and *Delbert P. Nachazel.*

Dr. Gillespie at Milwaukee

Dr. Calvin J. Gillespie left Antigo in late summer to assume his new post as staff consultant to the gynecological and obstetrical clinic at St. Luke's

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Physicians whose names appear in italics are members of the State Medical Society.

Hospital, Milwaukee. His duties, which commenced September 1, entail detection and treatment of cancer in women and management of obstetrical problems.

Dr. Springer Tells of Ship 'Hope'

Dr. J. P. Springer, Durand, who served aboard the Hospital Ship HOPE from December 1964 to the end of February 1965, explained the ship's operation to Menomonie Rotarians at a meeting at Menomonie in September.

Information Sought on Dr. Shenick

A request for information concerning the family of Dr. O. T. Shenick, a physician who was practicing in Peshtigo in 1881, has been received by Mrs. Perle Wolverton, Peshtigo librarian, from J. C. Higgins, Route 3, Komoka, Ontario, Canada. Mr. Higgins is a descendant of the Shenicks and is working on a family history.

Hospital Anniversary Addition

The Tenth Anniversary Open House held September 19 at Lancaster Memorial Hospital inspired an eight-page Anniversary Edition of the GRANT COUNTY INDEPENDENT on September 16 at Lancaster. Every phase of the hospital's administration and history was recounted in the profusely illustrated special section.

A front-page article related how plans for the hospital received a boost with the announcement that the will of Mrs. Lulu Williams had provided for the bulk of her estate (a sum of $80,000) to be left to the city of Lancaster for the building of a hospital. A stipulation of the will was that a bronze plaque should be placed on the front of the building bearing the words, "Dr. Sumpter Williams and Lulu Williams Memorial Hospital." Donations from interested individuals furthered the cause, among them one for $10,000 from Mrs. Rush Godfrey to equip a hospital operating room in memory of her husband, Doctor Godfrey, and his father, Dr. Joseph Godfrey.

Pictures on the edition's second page show the hospital's medical staff: *Drs. Kenneth Bauman, E. M. Houghton, H. W. Carey, G. C. Hillery, L. E. Becher*, all of Lancaster; *P. K. Edwards*, Bloomington; *J. J. David*, Cassville; and *E. C. Howell* and *C. H. Shields, Jr.*, Fennimore. Several Lancaster and Fennimore dentists also serve on the staff.

Dr. Wright Attends Course

Dr. Marvin Wright, member of the Bump Medical Group, Rhinelander, spent a week in September at Boston, Mass., attending a postgraduate course in gynecology at Harvard University Medical School.

MEDICAL STAFF

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Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
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Dr. Rudy Addresses PTA

A speaker for the opening meeting of the Everest High School Parent–Teacher Association September 20 in Wausau, *Dr. Warren Rudy* discussed health, emotions, and parental guidance of teenagers.

UW Faculty Men Present Seminar

The fulltime staff of the Section of Urology at the University of Wisconsin Medical Center in Madison has been expanded to three attending men: Drs. Paul O. Madsen, *David T. Uehling*, and *John B. Wear, Jr.*, as well as six residents. The three presented the first section of the program Saturday morning, October 2, when a seminar on "New Concepts in Diagnostic Urology" was held at the Center.

Doctor Uehling's subjects were "Intravenous Pyelogram" and "Cystogram and Urethrogram;" Doctor Wear presented "Cystoscopy" and "Cystometrogram," and Doctor Madsen, "Retrograde Pyelogram."

Presenting the second section of the program were *Dr. Jacob Martens*, "Cine-Voiding Cystourethrogram;" *Dr. Joyce Kline*, "Renogram (I 131)" and "Renoscan (Hg 203);" Dr. John D. Swingle, "Lymphangiogram;" and *Dr. Andrew Crummy*, "Nephrotomogram" and "Aortogram."

A tour followed the new Urology Diagnostic Clinics, which doubles University Hospitals facilities in the diagnosis and treatment of urological conditions in outpatients and inpatients.

Doctor and Mrs. Beebe Celebrate

Dr. and Mrs. *George W. Beebe* of Eau Claire celebrated their 60th wedding anniversary September 19 when their son and daughter-in-law, Mr. and Mrs. Thomas J. Beebe, entertained in their honor at the Congregational Church in Eau Claire. Doctor Beebe has practiced at Eau Claire since 1920. He was attending physician at the Eau Claire County Institutions for several years and he also served one term as county coroner.

Doctor Jonas Clinic Completed

The impressive new clinic building of *Dr. E. R. Jonas*, Ellsworth, has been completed. It opened the first week of October.

Doctor Heighway Has Associate

Dr. William N. Donovan is now an associate of *Dr. Thomas F. Heighway* in the general practice of medicine and surgery at Middleton. Doctor Donovan, a native of Madison, is a graduate of the University of Wisconsin Medical School. He served in the U.S. Army Medical Corps until October 1963 when he retired with the rank of Colonel. Doctor Donovan served as staff physician with the University of Wisconsin Student Health Service from 1963 to September 1965 when he joined Doctor Heighway.

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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Dr. Brooks Joins Racine Clinic

The Racine Medical Clinic in late September announced the association of *Dr. Jerome C. Brooks*, internal medicine, to the staff. Doctor Brooks, a lifelong resident of Fox Lake, received his bachelor of science degree in psychology from the University of Wisconsin in 1957. He then attended Marquette University School of Medicine at Milwaukee, graduating in 1961. The following year, Doctor Brooks served his internship at Mercy Hospital at Buffalo, N. Y. In July 1962 he accepted a residency in internal medicine which he completed in June 1965.

Addition to Marshfield Clinic Staff

Dr. Duane F. Pansegrau, a 1956 graduate of the University of Iowa medical school at Iowa City, has been added to the staff of the Marshfield Clinic as a general surgeon. Doctor Pansegrau, who practiced medicine at Carlstad, Minn., for two years, has just completed his residency in surgery at the University of Iowa and Veterans hospitals.

New La Crosse City Health Officer

Dr. Joseph A. Concello in early October started new duties as city health officer for La Crosse. He formerly was chief of preventive medicine at Olmsted Air Force Base in Pennsylvania. Doctor Concello obtained his medical degree from Hahnemann Medical College, Philadelphia, and interned at Hahnemann Hospital. After 3½ years in the Army, he was in general practice in Chester, Pa., for 16 years.

Dr. Yeazel Joins Madison Doctors

In late September *Dr. Roy V. Yeazel* became associated with *Drs. Sisk, Harper, Hobbins* and *Parks* in Madison. Doctor Yeazel graduated from Marquette University School of Medicine, Milwaukee, in 1961 and interned at Milwaukee Hospital. He recently completed a residency in general surgery at Madison General Hospital.

New Madison Hospital Site Unit Picked

A four-man committee was named October 7 by Madison Mayor Otto Festge to study site standards for a possible East side hospital. Two Madison physicians are members: *Dr. Charles Kincaid*, city public health director, and *Dr. Peter Golden*, of the Dane County Medical Society.

Eagle Medical Center Open House

Dr. and Mrs. Punislav Lekovic and Dr. and Mrs. Miodrag Pecarski attended the open house of the Eagle Medical Center September 25. Doctor Pecarski planned to open practice in Eagle immediately in connection with his practice in Dousman. Doctor Lekovic will begin practice as soon as his status as a permanent resident of the United States has been

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Anturane, brand of sulfinpyrazone, is available as white, scored tablets of 100 mg. Initially, give half a tablet 4 times daily with meals or milk, increasing in one week to one tablet q.i.d. Increase to two tablets q.i.d. if necessary, and reduce if possible to as low as half a tablet q.i.d. after control. Continue through acute attacks, which can be concomitantly treated with phenylbutazone.

Patients on other uricosurics may be transferred to this drug at full dosage.

Contraindications
Active peptic ulcer. Salicylates and citrates antagonize the drug's action and are contraindicated for concomitant use.

Warning
Use with caution in pregnant women.

Precautions
Keep patients under close supervision and make periodic blood counts. Use cautiously in patients sensitive to pyrazoles, in patients with histories of peptic ulcer, and in conjunction with sulfa drugs, the sulfonylurea hypoglycemic agents, and insulin, the actions of which may be potentiated.

In mobilizing urate deposits, the drug may precipitate acute attacks of gout, urolithiasis, and renal colic, especially in the initial stages of therapy. Ensure adequate fluid intake and alkalinize the urine. With renal impairment, test renal function periodically.

Adverse Reactions
The most frequent are upper gastrointestinal disturbances. The drug may activate peptic ulcer. Rash occurs infrequently. Although not reported to date, blood dyscrasias are a possibility.

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In most patients, the drug rapidly reduces serum uric acid levels to normal. This not only prevents new tophi but also mobilizes and promotes the excretion of urates already in the tissues. The reduction of tophi and periarticular crystals results in more mobile, less painful joints.

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Because of its potency, the drug is often effective in patients refractory to other uricosuric agents. Patients can usually be maintained indefinitely on it without cumulative effects or development of tolerance.

*Kuzell, W. C., et al.: Effect of sulfinpyrazone on serum uric acid in gout: a long-term study, Geriatrics 19:894, 1964.

Geigy

PHYSICIANS SPEAK AROUND THE STATE

Dr. Leigh Roberts, professor of psychiatry, UW Medical Center, at Madison vocational school, October 7, speaking on the relationship between a happy marriage and the emotional growth of the child.

Dr. Robert D. Coye, assistant dean of the UW Medical School, to the Madison Hospital Council, November 5, on "Trends in Medical Education."

Dr. Margaret Prouty, Madison pediatrician, to the Association of the Women's Students on the Platteville campus, September 27, on her recent mountain-climbing trip deep into the Himalayas.

Dr. Donald M. Rowe, industrial physician at Kohler Co., discussed heart ailment detection in industry at a meeting of Sheboygan Area Safety Council, September 28.

Dr. Glenn Bacon, Racine, to asthma victims attending a special exercise class conducted by the Racine YMCA, October 16.

Dr. Sanford Mackman, Madison, to Lake Geneva Parent Teachers Association, October 14, explaining how the increase in lung cancer, respiratory, heart and kidney diseases are paralleled to an increase in smoking.

Dr. Mildred M. Stone, Cuba City, to Women's Club members and guests, October 12, discussing the health of women.

Dr. William Backer, Wausau ophthalmologist, to Rib Mountain Lions Club members, October 12, explaining the eye disease, amblyopia, and the need for a projector and other equipment to test for this ailment in the eyes of preschool children.

Dr. Alvin Kurzon, Milwaukee gynecologist and obstetrician, to Mequon Health Volunteers, October 21, discussing "Problems After Forty."

Dr. Leslie G. Kindschi, chief of medicine at The Monroe Clinic and St. Claire Hospital, Monroe, at a day-long annual conference of Nutrition in Medicine at Rockford, Ill., October 8, on "The Role of Nutrition in Clinical Medicine."

Dr. N. O. Calloway, chief of medical service at the Veterans Administration Hospital, Tomah, to Marshfield Woman's Club, October 5, on the "White–Negro Problem."

Dr. D. M. Ruch, Milwaukee, to first fall meeting of Manitowoc Industrial Safety Council, September 23, reviewing causes of occupational dermatitis, its importance, prevention methods and proper management.

Drs. Ronald P. Karzel and *G. Leonard Apfelbach, Jr.*, Janesville, to Janesville Rotarians, September 27, on vascular and urologic problems.

Dr. N. A. Moffat, Marshfield urologist, to Wood County Medical Assistants Society, October 11.

established in the state department in Washington. His primary practice will be at Eagle, but Doctor Pecarski and Doctor Lekovic plan to practice together.

Physician Witnesses Medical Bill Signing

Dr. Dean Emanuel, president of the Marshfield Clinic Foundation, enjoyed a unique privilege in the nation's capital October 6 when he witnessed President Johnson's signing of the medical complex bill which provides $340 million to launch a research program against heart disease, cancer and stroke. Doctor Emanuel had been invited to the White House for the signing.

Dr. Simenstad Social Security Adviser

Dr. L. O. Simenstad, Osceola, in mid October was named by the Social Security Administration as a member of the advisory group on principles for reimbursing hospitals under the medicare program. The 31 advisers are composed of representatives of the medical profession, hospitals, health insurance organizations, and others involved in the health field. Doctor Simenstad is also a member of the AMA Board of Trustees.

Hospital Medical Staff Officers Elected

The following physicians have been elected officers of hospital medical staffs:

Berlin Memorial Hospital—*Dr. David Sievers*, chief of staff; *Dr. John Koch*, vice chief of staff; and *Dr. Steve Osicka*, secretary–treasurer; all of Berlin.

St. Clare Hospital, Baraboo—*Dr. F. W. Gissal*, Wisconsin Dells, chief of staff; *Dr. C. R. Pearson*, Baraboo, vice-president; and *Dr. G. J. Holmen*, Baraboo, secretary–treasurer.

Community Memorial Hospital, Menomonee Falls —*Dr. Donald Heyrman*, president; and *Dr. John D. Riesch*, president-elect; both of Menomonee Falls.

Holy Family Hospital, Manitowoc—*Dr. Nathan Davis*, president; *Dr. Daniel M. Pick*, vice-president; and *Dr. Walter F. Smejkal*, secretary; all of Manitowoc.

Memorial Hospital, Oconomowoc—*Dr. Clarence Samuelson*, Hartland, president; *Dr. John D. Wilkinson*, Oconomowoc, vice-president; and *Dr. G. Daniel Miller*, Oconomowoc, secretary–treasurer.

Doctor Dibble Writes Book

Dr. J. Birney Dibble, who has practiced surgery at Eau Claire since 1957, has written a book about his experiences as a medical missionary at a mission hospital in East Africa in 1962 and 1963. In his book, Doctor Dibble relates his personal experiences while in Africa. Its title is "In This Land of Eve." The author displays a keen sense of observation and his book contains vivid descriptions of the

country, the people, their customs and superstitions. He cites case histories of the diseases he treated and gives a factual description of life in the hospital. The book also contains accounts of big game hunting, the primitive tribal life and the political situation.

Dr. Hildebrand on Medic Alert Board

Dr. W. B. Hildebrand, Menasha, has been named a member of the National Advisory Committee of the Medic Alert Foundation, Turlock, Calif.

Dr. Roberts Named to Board

Dr. Leigh Roberts, assistant professor in the Department of Psychiatry at the University of Wisconsin Medical School, Madison, has been elected a new member of the corporation board of Methodist Hospital, Madison.

New Section Officers for O and O

New officers of the State Medical Society's Section on Ophthalmology and Otolaryngology are: *Dr. Frank Treskow*, Milwaukee, president; *Dr. Clemens Kirchgeorg*, Neenah, secretary; *Dr. Arthur Kissling*, Milwaukee, delegate; and *Dr. John W. Doolittle*, Madison, alternate delegate.

Dr. Baker, Tomahawk, Honored

Dr. R. G. Baker, Tomahawk, on September 16 was presented an award for 20 years' uncompensated service as a local board medical advisor to the Selective Service system. It was signed by President Johnson, Governor Knowles, and the national and state directors of Selective Service. Doctor Baker also received a pin in recognition of his service.

Dr. Stebbins Named to State Board

Dr. George G. Stebbins, Madison, was reappointed October 1 to the State Board of Health's Advisory Committee on Nursing Home Licensing and Regulation.

Dr. Larson, Ashland, Honored

Dr. Harry H. Larson, Ashland, was honored September 27 by members of the educational board of control with presentation of a resolution of appreciation and a gavel made from a desk used in the Ashland elementary schools which Doctor Larson attended as a youth. Doctor Larson was the first president of the board. The resolution expresses the board's appreciation for Doctor Larson's "service far beyond the normal call of duty" and states that "this board does in truth believe that the contribution of Harry H. Larson during the organization period of this activity will have a deep, lasting and constructive effect upon education in this area."

Physician in Marital Counseling Role

Dr. Warren Williamson, Racine, joined two pastors and an attorney in a unique cooperative effort to counsel married couples on the religious, social, sexual, and legal aspects of marriage. The counseling service, called "Marital Seminar," began October 8 and continued one night a week for five weeks.

Dr. Sickels Joins Riverside Clinic

Riverside Clinic, Menasha, announced in October the addition of Dr. William F. Sickels to its medical staff. Doctor Sickels, who is a specialist in

PERMANENT COMMISSION OF MUSEUM OF MEDICAL PROGRESS MET OCTOBER 16, PRAIRIE DU CHIEN

Several members of the Permanent Commission of the Museum of Medical Progress met Saturday, October 16, in Prairie du Chien to discuss the current season's activities and to formulate and discuss future exhibit plans for the Museum and Stovall Hall of Health. Attending were *Doctors Gunnar Gundersen*, La Crosse, *E. J. Nordby*, Madison, *W. D. Stovall*, Madison, Robert A. Mason (Wisconsin State Dental Society), Oconomowoc, and Mrs. F. H. Wolf (Woman's Auxiliary), La Crosse.

A report on the attendance at the Museum through September 30 showed that 15,037 visitors had been registered. For the same period in 1964, 14,167 people had visited the Museum, and this resulted in a net increase of 870 for the period. It was also reported that the floods in Prairie du Chien had a great affect on attendance at the end of April and in early May, and this is one of the reasons why attendance was not as high as expected for this period.

Admission charges for 1966 were established: $1.00 for a family admission and 50¢ for a single adult admission.

Plans for the 1966 exhibit season include the assembling of an exhibit on the stethoscope. Old-time and modern stethoscopes will be shown with a hearing-type of device so that visitors may listen to the improvement in quality over a century and a half.

A hearing exhibit is also in process of preparation. An exhibit centered around a 100-year-old drugstore counter is being developed. A history of tuberculosis control in Wisconsin will be the theme of another exhibit now in the developing stage. Arrangements are being completed for a nursing exhibit supported by the Wisconsin Nurses Association.

The Museum and Stovall Hall of Health closed for the season November 1. Members of the State Medical Society are invited to make recommendations and offer assistance to the Permanent Commission in its direction of Museum operations. Communications should be directed to: Mr. Norman J. Salt, Director, CES Foundation, Box 1109, Madison, Wis. 53701.

internal medicine and diagnosis, was born in Milwaukee. His medical education was received at Northwestern University School of Medicine where he graduated in 1961. Doctor Sickels interned at Wesley Memorial Hospital, Chicago, in 1962. He served his residency as a fellow at the Mayo Clinic, Rochester, Minn., during 1962 through 1965. While at the Mayo Clinic, Doctor Sickels had special training in diseases of the kidney. Doctor Sickels and his family reside in Neenah.

Dr. Falk on Family Service Board

Dr. M. J. Falk, Green Bay, has been appointed to fill a two-year unexpired term on the board of directors of Family Service Association, a United Fund agency.

Participants in Heart Association Meeting

Dr. Hugh J. McLane of Fond du Lac was one of several Wisconsin men who represented the state at the annual meeting and scientific sessions of the American Heart Association in Bal Harbour, Fla., October 15–19. Other physicians who planned to attend the meeting are *Dr. Ross C. Kory* and *Dr. Derward Lepley, Jr.* of Milwaukee, Dr. William B. Youmans, Madison, and *Dr. William B. Hildebrand*, Menasha.

Physicians presenting papers at the scientific sessions were *Dr. Sanford J. Larson* and *Dr. John B. Baker* of Milwaukee, and *Dr. John R. Sadd* and *Dr. John T. Mendenhall* of Madison.

Dr. Fischer on Rehab Group

Dr. Herbert Fischer, Marshfield, department of physical medicine, Marshfield Clinic, in September was appointed a member of a newly organized committee which has been created to coordinate vocational rehabilitation efforts in Wood County.

Marshfield Doctors Present Heart Exhibit

Dr. Dean A. Emanuel and *Dr. Richard D. Sautter* of the cardiovascular team at the Marshfield Clinic presented an exhibit on pulmonary embolism at the American College of Surgeons meeting October 18–22 at Atlantic City, N. J. This is the same exhibit which won top honors at the State Medical Society annual meeting in May at Milwaukee.

Joins Gundersen Clinic Staff

Dr. John B. Weeth joined the internal medicine staff of the Gundersen Clinic, La Crosse, in September. A native of New York State, he attended State University of New York, College of Medicine, at New York, and received his M.D. degree in 1952. He served his internship at the Brooklyn Hospital, Brooklyn, after which he spent two years of active duty in the Navy Medical Corps. He then finished his training as a fellow in internal medicine and endocrine research at Ochsner Foundation Hospital, New Orleans, La., from 1955 to 1958.

After his residency training, he joined the staff of Ochsner Clinic in internal medicine and endocrine research. He worked with new and investigational treatments of malignancies and has been a

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participant in cancer therapy programs of the National Institutes of Health. Doctor Weeth, who came to La Crosse directly from the Ochsner Clinic, is a diplomate of the American Board of Internal Medicine.

Helen Halverson Visiting Professor

Dr. Eben Alexander, professor and chairman of Neurological Surgery, Bowman Gray School of Medicine, was Helen Halverson Visiting Professor of Neurological Surgery at the University of Wisconsin from November 2 to 5. The Visiting Professorship is provided by Mr. Harold F. Halverson of Beloit and family in memory of Mrs. Helen Halverson.

Physicians New Fellows of ACS

Twenty-six Wisconsin physicians were among the approximately 1,175 surgeons who were inducted as new fellows of the American College of Surgeons at its annual five-day Clinical Congress held in October at Atlantic City, N. J. Physicians receiving the distinction are: *Gilbert F. Mueller, Jr.*, Appleton; *George F. Woodington*, Beloit; *Bertram I. Milson* and *Robert T. Schmidt*, Green Bay; *Rollo D. Lange, William A. Kisken, Paul J. Radlet, John P. Rahm, Jr., Charles R. Taborsky, John B. Wear, Jr.*, and James D. Whiffen, Madison; *Harold L. Gerndt, Jr.*, Manitowoc; Alan B. Cameron, Marshfield; *Frank E. Berridge, Benjamin F. Shockley, Jack D. Spankus*, and *Charles L. Weisenthal*, Milwaukee; *Stanley J. Nuland*, Platteville; *Donald R. Burke* and *Arthur J. Jacobsen*, Racine; *Paschal A. Sciarra*, Sheboygan; *Philip A. Zlatnik*, Two Rivers; *Paul E. Carroll, Charles A. Desch*, and *Richard G. Frantz*, Waukesha; and *Clifford H. Starr*, Wisconsin Rapids.

Honor Edgar's Doctor Schulz

An entire community turned out September 26 to honor *Dr. H. A. Schulz*, who has served the Edgar area in both a medical and civic capacity the past 35 years. Among the many gifts received by the doctor was a new examining table. Scores of those stopping to chat with him had him autograph the booklet put out by the "Dr. Schulz Committee."

Attend Scotland Meeting

Drs. George E. Collentine, Jr. and *John D. Conway*, Milwaukee, participated in the Second International Congress for Research in Burns, held in Edinburgh, Scotland, September 20–24.

Participant in Occupational Health Meet

Dr. O. A. Sander, Milwaukee, participated in a symposium, "Role of the Family Physician in Employee Health Problems," at the AMA Congress on Occupational Health in Indianapolis, October 12–14.

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Dr. Shahrokh Speaking Engagements

Dr. Darius K. Shahrokh, otolaryngologist of Fond du Lac Clinic talked to the following groups on "Conservation of Hearing and Current Treatment for Deafness": August 3 at the monthly staff meeting of the Plymouth Hospital; September 25 at the annual convention of the Wisconsin Society of X-Ray Technicians held in Appleton; September 30 at the Fall in-service education meeting of Public Health Nurses of Third District held in Fond du Lac.

On Panel Discussion of Southern Negro

Dr. John Harkness, a Wauwatosa pediatrician, moderated a panel discussion October 19 by a group of volunteer workers who recently returned from the South where they worked directly with the southern Negro, giving aid where needed—voter registration, setting up libraries, reading instruction. The meeting was sponsored by the Wauwatosa Council for Intercultural Understanding.

Madison Physicians in Heart Forum

Four Madison heart specialists and a heart surgeon were on a panel of experts participating in the free public heart forum held October 5 at the Dane County Fairgrounds in Madison. They are: *Dr. A. J. Richtsmeier, Dr. John Morledge, Dr. Robin N. Allin*, and *Dr. Charles Crumpton*, all cardiologists, and *Dr. William P. Young*, the cardiovascular surgeon.

They joined Dr. Howard B. Sprague, Boston, main speaker at the meeting, in answering questions about heart disease submitted by the public. The free forum, sponsored by the Dane County Unit of the Wisconsin Heart Association and Madison Newspapers, Inc., was offered to alert the public on the latest developments in the fight against heart disease.

Dr. William S. Middleton, emeritus dean of the University of Wisconsin Medical School, moderated the program. Members of the Dane County Medical Auxiliary and their daughters served as ushers and were in charge of decorations.

Dr. Studley's Appointment Confirmed

The state Senate October 5 unanimously confirmed four appointments by Governor Knowles to the State Board of Public Welfare. Among those confirmed was the reappointment of *Dr. William H. Studley*, Milwaukee.

Marquette–Jackson Clinic Meeting

The Thirty-fifth Annual Marquette–Jackson Clinic Postgraduate Meeting was held October 7 at the Park Motor Inn, Madison. Doctor registration totaled 73. *Dr. Luther E. Holmgren*, president of the Jackson Clinic staff, welcomed the participants.

Members of the Clinic staff who presented papers were: *Dr. John J. Mueller* (urology), The Solitary Kidney—Recognition and Management; Dr. Blake E. Waterhouse (medicine/gastroenterology), Ulcera-

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tive Colitis—Newer Concepts of Pathogenesis and Treatment; and *Dr. David G. Bryant* (orthopedic surgery), Surgical Treatment of Rheumatoid Arthritis. *Dr. D. William Hurst* (medicine), moderated a panel discussion on Diabetes Mellitus—Recent Concepts of Pathophysiology; Medical, Surgical, and Obstetrical Management. Participants were *Dr. William J. McAweeney, Dr. Louis F. Warrick, Dr. Luther E. Holmgren,* and *Dr. David L. Williams* (medicine, surgery, obstetrics and gynecology).

Marquette speakers were: *Dr. Thomas R. Sawyer* (clinical instructor, ophthalmology), The Differential Diagnosis and Treatment of Exophthalmos; *Dr. Albert H. Pemberton* (assistant clinical professor, general and thoracic surgery), Newer Aspects of Treatment of Bronchogenic Carcinoma; and *Dr. William J. Gallen* (assistant professor of pediatrics), Recognition and Management of Heart Failure in Infancy and Childhood.

Following a dinner to which the wives were also invited, Mr. John Reynolds of the Wisconsin Taxpayers Alliance addressed the group on What the 1965 Legislature Did to YOU.

SACRED HEART SANITARIUM CHANGES NAME

To better reflect the true nature and function of the Sacred Heart Sanitarium at Milwaukee, the name has been officially changed to Sacred Heart Rehabilitation Hospital, effective October 1.

Founded in 1893 as a health center, it specialized in the most advanced kinds of water and massage restorative treatments developed and practiced by leading European physicians. As early as 1902, however, the Sanitarium had begun its expansion into a multi-purpose health institution, and as this progress and development continued the original name less and less reflected the true nature and functions of the hospital. Nor did it duly recognize the institution's status as a hospital, accredited as such by American Hospital Association since hospital standardization was inaugurated. These considerations, coupled with plans for the future direction and scope of patient service point to Sacred Heart Rahabilitation Hospital as the most appropriate and descriptive name.

It should be emphasized, however, that none of these changes indicate any radical departure from past practice or tradition but rather a continuation and intensification of the normal evolutionary progress that has been taking place over the years. The rehabilitative services of the hospital will be concentrated in four general categories of patients: general medical, neurological, the mild emotionally ill, and postoperative convalescence. Particular emphasis will be placed on the care of patients suffering from stroke. While the majority of these types of patients will require hospitalization for limited periods of time, facilities are also planned for some long-term patients requiring continuous care service within the hospital setting.

Patients will be admitted on referral of their physicians either directly to Sacred Heart Rehabilitation Hospital or as transfers from general hospitals. Physical therapy treatment, which has long been a major function of the hospital, will be further developed by the allocation of additional space and the purchase of new equipment. Plans for the installation of new laboratory facilities are also underway. As a rehabilitation oriented hospital, present plans do not envision the operation of an emergency treatment center or major surgical procedures.

Talk on Birth Defects

Two Milwaukee physicians were speakers at a symposium on "Birth Defects" sponsored by the Milwaukee County Chapter of the National Foundation, October 21 and 22 at the Holiday Inn Central, Milwaukee.

Dr. Frederick Gaenslen spoke on "Congenital Heart Malformations." He is assistant clinical professor of orthopedic surgery at Marquette University. *Dr. Sidney K. Wynn* discussed "Skin Defects and Plastic Surgery." He is associate clinical professor of plastic surgery, Marquette University, and chief of plastic surgery, Milwaukee Children's Hospital, Mt. Sinai Hospital, and Milwaukee County Hospital.

State Hospital Hosts Clergymen

About 100 ministers and priests attended a clergymen's institute on the subject, "Understanding the Adolescent," in late September at Winnebago State Hospital, Oshkosh. The program was presented principally by staff members from the hospital's children and adolescents' unit. Welcoming the group on behalf of the hospital was *Dr. Darold A. Treffert*, superintendent.

Doctor Treffert and *Dr. Stanley Miezio*, psychiatrist in charge of the children and adolescents' unit at Winnebago, addressed the participants during the program.

New Physician at Arcadia

A second physician recently arrived in Arcadia to establish a general practice in the Arcadia Medical Center. She is Dr. Lois Zimmerman who recently returned to the United States after five and a half years as a general practitioner and surgeon at Ganta Methodist Hospital, Ganta, Liberia, West Africa. She is now associated with *Dr. Thomas P. Chisholm*. Doctor Zimmerman received her M.D. degree from Ohio State Medical School, Columbus.

Dr. Louis E. Fazen, Sr., 89, who had practiced medicine in his native Racine for 65 years prior to his retirement last March, died Aug. 15, 1965, at his residence in Racine. He had been described by a colleague as "the first recognized general surgeon in Racine . . . considered by many . . . as the father of surgery in southeastern Wisconsin."

A registered pharmacist at the age of 18, he went on to win his doctor of medicine degree in 1900 from Northwestern University Medical School. Of interest is the fact that his son, Dr. Louis E. Fazen, Jr., Racine, was a graduate of Northwestern in 1940, and his grandson, Louis E. Fazen, III, is now a freshman medical student there.

Surviving Doctor Fazen in addition to his physician son are four other children: Mrs. Marvin Hueffner and Mrs. H. Ernest Munch, Racine; Mrs. Theodore Larson, Milwaukee, and Mrs. Kenneth McKivett, Cudahy.

Doctor Fazen was a founding member and had served several terms as president of the Racine County Medical Society. He was also a founding member, in 1914, of the Wisconsin Surgical Association, a fellow of the American College of Surgeons, and a member of the Wisconsin Academy of Medicine, the American Railway Surgeons, the American Association of Industrial Physicians and Surgeons, the State Medical Society of Wisconsin, and the American Medical Association. During World War II he served as a consultant for the Racine Selective Service Board.

Doctor Fazen organized the active medical staff at St. Mary's Hospital, Racine, and was chief of staff and chief of surgery there from 1915 until 1940 when he was given emeritus status in both. He had also served on the staff of St. Luke's Hospital. A bronze plaque paying tribute to his service has been on view at St. Mary's Hospital since 1961. A memorial room portraying the history of medicine in Racine County has been established in Doctor Fazen's honor in the Racine County Historical Museum.

Worthy of note is Doctor Fazen's cancellation of all accounts receivable on his death. Notice to this effect was carried in the RACINE JOURNAL TIMES.

Dr. Leon D. Sobush, Manitowoc physician and surgeon, died Aug. 18, 1965, at the age of 56.

A Green Bay native, Doctor Sobush received his M.D. degree in 1935 from Marquette University School of Medicine, Milwaukee, and interned at Milwaukee County General Hospital. He had served on the staffs of Two Rivers Municipal Hospital, Two Rivers, and Holy Family Hospital, Manitowoc. He was a member of the Manitowoc County Medical Society, in which he served three terms as secretary-treasurer, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Sobush is survived by his daughter, Miss Bonnie, Manitowoc, and five sons, Daniel, Miami, Fla.; Leon, Jr., Michael, Andrew, and David, all of Milwaukee.

OBITUARIES

Dr. Otis M. Wilson, Wausau eye, ear, nose and throat specialist, died Aug. 20, 1965, in Wausau at the age of 68.

Doctor Wilson, who was born near Aurora, Ind., was a 1928 graduate of the University of Wisconsin Medical School. He served his internship and residency from 1928 to 1930 at Indianapolis City Hospital and had practiced in Wisconsin since 1930. During the latter part of his career he specialized in ophthalmology. He had served on the staffs of Wausau Memorial, where for many years he was secretary, and St. Mary's Hospitals, Wausau.

He was a member of the Marathon County Medical Society and its president in 1946, the State Medical Society of Wisconsin, the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, the Pan American Association of Ophthalmology, World Medical Society, American College of Surgeons, and the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology.

Doctor Wilson was a big-game hunter who had hunted in Alaska and the Hudson Bay area as well as Equatorial Africa. Recently he and his wife had traveled extensively in Europe and the Near East, especially the Holy Land. On their last trip there, the two climbed Mt. Sinai, focusing on Petra, an ancient city south of the Dead Sea. They were in the process of preparing a book on Petra and the Holy Land.

Surviving Doctor Wilson in addition to his widow are a daughter, Mrs. C. S. Scheffler, Park Falls, and a son, Louis, Stillwater, Okla.

Dr. Max Bornstein, life member of the State Medical Society of Wisconsin since 1959 and a member of the 50 Year Club since 1958, died Aug. 21, 1965, at his home in Milwaukee. He was 77.

Born in New York, Doctor Bornstein was a 1908 graduate of Jefferson Medical College, Philadelphia, Pa. His internship and residency were served at Mount Sinai Hospital, Milwaukee, and Philadelphia General Hospital, Philadelphia, and he also did postgraduate work in plastic and brain surgery at Washington University, St. Louis, Mo.

He was chief of staff at Mount Sinai Hospital from 1934 to 1937. In 1961, the hospital awarded him a certificate of recognition for his half century of service. He was a fellow of the American College of Surgeons, a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Survivors include a daughter, Mrs. Robert H. Apple of Shorewood.

Dr. Robert E. Yunck, Milwaukee internist and assistant clinical professor of medicine at Marquette University School of Medicine, died Aug. 21, 1965, while vacationing at Colorado Springs. He was 49.

After receiving his medical degree in 1942 from Marquette, Doctor Yunck served an internship and then a residency at Milwaukee County General Hospital. From 1945 to 1947 he was a clinical assistant in internal medicine at the University of Illinois, and preceptor in internal medicine and gastroenterology assisting Dr. Ralph C. Brown, Chicago. Throughout the rest of his career Doctor Yunck practiced in Milwaukee.

He was a staff member of Columbia, St. Mary's, Milwaukee County General, Milwaukee, St. Anthony's, and Misericordia Hospitals and in 1962 was chief of staff at Misericordia.

Doctor Yunck was a diplomate of the American Board of Internal Medicine, a fellow and an associate of the American College of Physicians, and a member of the American Heart Association, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, Wisconsin Society of Internal Medicine, Milwaukee Academy of Medicine, Milwaukee Internists Club, and the Milwaukee Gastroenterological Society, which he served as president in 1957–1958.

Surviving is a sister, Miss Gertrude Yunck, Milwaukee.

Dr. Lewis A. Moore, dean of Green County physicians, died Sept. 2, 1965, in Monroe, where he had practiced for nearly 60 years. The 89-year-old doctor, who had been health officer of the city of Monroe for many years, started practice in that community in 1907 and maintained the same office from then on until moving it to his home this past summer.

Born in Kewanee, Ill., Doctor Moore was graduated from Rush Medical School in 1900 and interned at Presbyterian Hospital, Chicago, until 1903. He then became a physician for the Oliver Mining Company, Ely, Minn., and later practiced briefly at Tower, Minn.

As a major and surgeon in the Third Wisconsin Infantry, Doctor Moore served at Fort Sam Houston, Tex., for six months in 1916 during the Punitive Expedition against Mexico. In World War I he was regimental surgeon with the 128th Infantry, 32nd Division, and in January 1919 he was named acting surgeon of the division.

Doctor Moore had been a life member since 1960 of the State Medical Society of Wisconsin and a member of the 50 Year Club since 1950. He was a member, also, of the Green County Medical Society, which he had served both as president and secretary, and the American Medical Association. In addition to his professional affiliations he played an exceedingly active role in numerous fraternal, civic, and military organizations. He was named Monroe's outstanding senior citizen by the Monroe Junior Chamber of Commerce in 1961, and the following year the Monroe Rotary Club recognized his 87th birthday with a "This Is Your Life" observance.

Surviving are two daughters, Mrs. John F. Towle, Philadelphia, Pa., and Mrs. John R. Collins, Kendall, and five grandchildren.

An editorial in the MONROE EVENING TIMES lauded him as the community's "outstanding citizen . . . a genuine patriot . . . a civic pioneer, and the deserved recipient of countless organizational plaudits . . . a man gifted with talents for healing the sick and ministering to the downtrodden through his seemingly boundless energies."

* * *

COBALT 60 UNIT FOR TREATMENT OF CANCER PATIENTS INSTALLED AT DOCTORS HOSPITAL

A $70,000 installation for cobalt 60 and conventional radiation therapy equipment to be used in treating cancer patients was scheduled for completion in September at Doctors Hospital, Milwaukee.

Under a unique arrangement, the cobalt therapy unit will be available to all physicians who are specialists in radiation therapy, and their patients, not only physicians practicing at Doctors Hospital, according to Walter G. Harden, administrator.

An "open-staff" program has been made possible by cooperative planning of the hospital's Board of Trustees and Medical Staff, whereby all qualified physicians will be able to utilize the services of Doctors Hospital and its Radiation Therapy Department. The patient will remain under the supervision of his attending physician, Harden said.

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An organization for physician volunteers for overseas medical service

Group sponsorship of short-term physician volunteers on a continuing basis to overseas hospitals is a gradually growing program. One of these groups, AMDOC, INC., has been organized for the purpose of putting physicians, who wish to give of their time and experience to needy areas, in contact with those areas which are in need of physicians' services. There is no financial assistance. Physicians travel at their own expense, unless they acquire a sponsoring organization.

AMDOC's main accomplishment has been in areas of Central America, South America, the Carribean, Africa, and the Far East. AMDOC is supported by voluntary contributions of from $15 or more by interested parties. AMDOC is a low budget organization and plans to remain so.

Further information is available by writing to: David P. Hansford, MD, President, AMDOC, 27 East Canon Perdido Street, Santa Barbara, Calif. 93101.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 22, 1965

NEW MEMBERS

Fred G. Bedford, 39969 Division St., Oconomowoc.
James D. Cardy, 3237 S. 16th St., Milwaukee.
Donald J. Chrzan, 1729 S. 11th St., Milwaukee.
James C. M. Chung, 316—5th St., Racine.
Richard M. Clifford, 5914 W. Roosevelt Dr., Milwaukee.
Carol K. Haller, 2900 W. Oklahoma Ave., Milwaukee.
E. Basil Jackson, 161 W. Wisconsin Ave., Milwaukee.
Charles R. Lipscomb, 1004 N. 10th St., Milwaukee.
Howard Lokietz, 945 N. 12th St., Milwaukee.
Jose R. Relacion, 2900 W. Oklahoma Ave., Milwaukee.
James R. Schmidt, 6026 W. Washington Ave., Wauwatosa.
Roy V. Yeazel, 1 S. Pinckney St., Madison.

REINSTATED

Raymond H. Quade, Box 338, Sedona, Ariz.

CHANGES OF ADDRESS

Luca Alverno, Milwaukee, to Via Palestro 12, Genoa, Italy.
L. M. Baertsch, 507 E. 1st St., Hayward.
Rudolph Balzer, 1410 N. 27th St., Milwaukee 53208.
Donald F. Barcome, Houston, Tex., to 2424 Olson Dr., Grand Forks, N.D. 58201.
N. O. Becker, 505 E. Division St., Fond du Lac 54935.
C. H. Behnke, 400 Ceape Ave., Oshkosh 54901.
Robert Bein, 3128 Taylor Ave., Racine 53405.
Joseph C. Belshe, Minneapolis, Minn., to 1000—24th Ave. N., St. Cloud, Minn. 56301.
George A. Berglund, Wauwatosa, to 811 E. Wisconsin Ave., Milwaukee.
Richard E. Bilbo, Elm Grove, to 157 Chatham Rd., Syracuse, N.Y. 13203.
John Z. Bowers, Kyoto, Japan, to 16 W. 46th St., N.Y., N.Y. 10036.
Edward J. Buerger, 3064 N. 52nd St., Milwaukee.
Larry C. Carey, Milwaukee, to 13005 Elmhurst Pkwy., Elm Grove 53122.
W. E. Clark, 400 Ceape Ave., Oshkosh 54901.
Thomas H. Cooper, Janesville, to 732 Cottage St. N.E., Salem, Ore. 97301.
Robert E. Cullen, 104 S. Main St., Fond du Lac 54935.
E. F. Cummings, 400 Ceape Ave., Oshkosh 54901.
Luis B. Curet, Madison, to Yale Univ. Medical School, New Haven, Conn.
H. J. Danforth, 400 Ceape Ave., Oshkosh 54901.
Alfonso Deiparine, Jr., West Allis, to 620 N. 19th St., Milwaukee.
Mario M. de Oliveira, 1545 S. Layton Blvd., Milwaukee.
Silas M. Evans, 811 E. Wisconsin Ave., Milwaukee 53202.
Kenneth R. Fick, West Allis, to 417 S. Main St., Oconomowoc 53066.
Milton Finn, 3600 Tower Ave., Superior.
Laurence M. Flanary, Wauwatosa, to 10425 W. North Ave., Milwaukee.
Richard T. Flynn, Jr., Wood, to Route 2, Box 123, East Troy.
Burton J. Friedman, 836 N. 12th St., Milwaukee.
Howard I. Gass, Milwaukee, to 2827 N. Wisconsin St., Racine.
W. David Gemmill, Menasha, to 108 W. Wisconsin, Neenah.
Walter J. Gerstle, Kenosha, to 70 Clermont, Albany, N.Y. 12203.
Lance G. Glasson, Beaver Dam, to 218 Flagler Ave., New Smyrna Beach, Fla. 32069.
Vincent L. Gott. Madison, to Johns Hopkins Hospital, Baltimore, Md. 21205.
B. S. Greenwood, 400 Ceape Ave., Oshkosh 54901.
J. E. Habbe, 231 W. Michigan St., Milwaukee 53203.
Nesim Halfon, 7301—5th Ave., Kenosha.
John Hartwick, 1710 S. East La., New Berlin.
Dayton H. Hinke, Madison, to Marshfield Clinic, Marshfield 54449.
Jerome W. House, Jr., Fort Leonard Wood, Mo., to 4036 N. 51st Blvd., Milwaukee 53216.
Audrey L. Huckaby, Milwaukee, to 239 S. Wilshire Dr., Cedarburg 53012.
John F. Imp, 4835 W. Capitol Dr., Milwaukee.
P. S. Johnson, Racine, to 3007 Geddis Ave., Ann Arbor, Mich. 48105.
Anthony Jurisic, Spring Valley, to 17435 Alvin La., Brookfield 53005.
Paul L. Karrmann, Jr., 917 Reed Ave., Manitowoc 54220.
Robert A. Kebbekus, 811 E. Wisconsin Ave., Milwaukee 53202.
Warren H. Kempinsky, Milwaukee, to 8605 Ravenswood Circle, Wauwatosa.
Gerald A. Kerrigan, 561 N. 15th St., Milwaukee.
Harold J. Kief, 505 E. Division, St., Fond du Lac 54935.
Howard M. Klopf, Milwaukee, to N84 W16689 Menomonee Ave., Menomonee Falls.
Peter Lameka, Rice Lake, to N5077 Lakeshore Dr., Oconomowoc 53066.
Gordon E. Lang, Madison, to 2557 N. Lake Dr., Milwaukee 53211.
Jean Lang. Madison, to 2357 N. Lake Dr., Milwaukee 53211.
Carl J. Levinson, 945 N. 12th St., Milwaukee.
I. E. Levitas, Green Bay, to 930 Hickory Ave., De Pere 54115.
J. W. Lowe, 1575 N. Shore Dr., Eau Claire.
Alexander J. MacGillis, Rochester, N. Y., to 2040 W. Wisconsin Ave., Milwaukee.
James W. MacGregor, 213 W. Cook St., Portage 53901.
F. Fuller McBride, Milwaukee, to 95 Meadowbrooke Blvd., Fond du Lac.
Peter L. McDermott, Milwaukee, to 905 Devonshire, Oxnard, Calif. 93032.
John R. McKenzie, Jr., Brookfield, to 415 S. Meadow, Oshkosh.
Clement A. Meilicke, 400 Ceape Ave., Oshkosh 54901.
Harvey Monday, 400 Ceape Ave., Oshkosh 54901.
James E. Morgan, 324 E. Wisconsin Ave., Milwaukee.
G. F. Mueller, 6142 N. Lydell, Milwaukee 53217.
W. E. Myers, 505 E. Division St., Fond du Lac 54935.
Albert A. Nemcek, 3735 N. 96th St., Milwaukee.
James E. Ney, 7635 W. Oklahoma Ave., Milwaukee.
Robert J. Nickels, Saginaw, Mich., to 141 Cherry St., Campbellsport 53010.
W. J. O'Leary, Jr., S. Milwaukee, to 10937 W. Cortez Road, Franklin 53132.
John U. Peters, 505 E. Division St., Fond du Lac 54935.
J. T. Petersik, 400 Ceape Ave., Oshkosh 54901.
Lyndle W. Peterson, Dania, Fla., to 117 E. Green Bay St., Shawano 54166.
Oliver W. Pfeiffer, Shorewood, to 4609 N. Marlborough, Milwaukee 53211.

Charles J. Pophal, 8410 W. Cleveland Ave., Milwaukee.

Daniel J. Price, 7751 N. Fairchild, Milwaukee.

W. A. Pruett, 2031 Riverside Dr., Beloit.

Arthur A. Rand, Milwaukee, to 10440 Queens Blvd., Apt. 20V, Forest Hills, N. Y.

John G. Rawland, Milwaukee, to Box 866, Moorehead, Minn.

Jose R. Relacion, Milwaukee, to 910 N. Elm Grove Rd., Elm Grove 53122.

Shafik F. Richany, Durham, N. C., to Walter Reed Army Medical Center, Washington 25, D. C.

T. H. Rolfs, 423 E. Lexington Blvd., Milwaukee 53217.

William C. Rouman, Elm Grove, to 400 Silver Spring Dr., Milwaukee.

Daniel G. Santer, 3321 N. Maryland, Milwaukee.

Frederick Schaefer, Menasha, to 1209 S. Commercial, Neenah 54956.

W. R. Schatz, Modesto, Calif., to 2043 Douglas Ave., Racine.

Hugo Schlagintweit, Arcadia, to 21404 River Rd., Haney, B. C., Canada.

Thomas A. Schroeder, Milwaukee, to 111 N. Park St., Oconomowoc 53066.

Dale R. Shampo, Richland Center, to 279 N. Railroad Ave., Staten Island, N. Y. 10304.

John C. Shields, Wausau, to 1324 Schofield Ave., Schofield 54476.

Porter H. Smith, Milwaukee, to 437 Sippewissett Rd., Falmouth, Mass. 02540.

M. H. Steen, 400 Ceape Ave., Oshkosh 54901.

Margery Jean Swint, Milwaukee, to 107 Goucher Circle, Oak Ridge, Tenn.

Richard R. Teeter, Milwaukee, to Ancker Hospital, St. Paul, Minn.

Eugene S. Turrell, Wauwatosa, to 111 E. Wisconsin Ave., Milwaukee.

Donald P. Ullrich, 811 E. Wisconsin Ave., Milwaukee.

Raymond K. Voet, Milwaukee, to 1100 Como Ave. S.E., Apt. 14, Minneapolis, Minn.

Kenneth E. Vogel, Milwaukee, to Charity Hospital, New Orleans, La.

Thomas W. Weis, Joliet, Ill., to 12121 Juniette St., Culver City, Calif. 90230.

Edwin C. Welsh, 2900 W. Oklahoma Ave., Milwaukee.

James A. Wenders, Milwaukee, to 10247 W. National Ave., West Allis 53227.

George E. Whalen, Jr., 425 E. Wisconsin Ave., Milwaukee.

Anthony P. Ziebert, Milwaukee, to 10247 W. National Ave., West Allis 53227.

REMOVED FROM MEMBERSHIP

Anthony C. Hahn, Jefferson County, resigned.

Raymond L. Hansen, Clark County, transferred to Minnesota.

Raymond J. Winkler, Shawano County, removed per county secretary.

DEATHS

Lawrence C. Sass, Milwaukee County, July 21, 1965.

Karl Schlaepfer, Milwaukee County, August 1, 1965.

James L. Wardlaw, non-member, August 15, 1965.

Louis Edward Fazen, Racine County, August 15, 1965.

Milo E. Swanton, Outagamie County, August 17, 1965.

Leon D. Sobush, Manitowoc County, August 18, 1965.

Otis M. Wilson, Marathon County, August 20, 1965.

Robert E. Yunck, Milwaukee County, August 21, 1965.

Max Bornstein, Milwaukee County, August 21, 1965.

Fred W. Sachse, Washington County, August 26, 1965.

Earl V. Hicks, Green County, September 1, 1965.

Lewis A. Moore, Green County, September 2, 1965.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

1965 **Wisconsin**

Dec. 1: "In Depth" teaching program, "Problems Encountered in Aging Process" (Medicine), SMS headquarters, Madison.

1966

Jan. 20: "In Depth" teaching program, "Problems of Elderly Patients" (Surgery and Anesthesia), SMS headquarters, Madison.

Feb. 4–6: Annual scientific meeting, Wisconsin Psychiatric Association, The Abbey on Lake Geneva, Fontana.

Feb. 15–17: Mt. Telemark Medical Symposium and Ski Outing, Indianhead Chapter of the WAGP, Mt. Telemark Ski Chalet, Cable.

Feb. 16: "In Depth" teaching program, "Problems of Elderly Patients" (Dermatology and EENT), SMS headquarters, Madison.

Mar. 9, 16, 23, 30: Marquette University School of Medicine, postgraduate course in hematology, Milwaukee.

Mar. 24: "In Depth" teaching program, "Problems of Elderly Patients" (Neurology), SMS headquarters, Madison.

Mar. 31–Apr. 2: University of Wisconsin Medical School, postgraduate program on "Viruses and Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 7, 14, 21, 28: Marquette University School of Medicine, postgraduate course on chemotherapy of infectious diseases, Milwaukee.

May 5–7: University of Wisconsin extension division, "Radiology and Pathology of Genitourinary System," Wisconsin Center, Madison.

May 10–12: State Medical Society, annual meeting, La Crosse.

May 21: Wisconsin Heart Association, 18th annual meeting, Wisconsin Center, Madison.

June 17: Wisconsin Academy of General Practice, Lederle symposium, Wausau Club, Wausau.

June 2–4: University of Wisconsin Extension Division, psychiatric program, Wisconsin Center, Madison.

1965 **Neighboring States**

Dec. 4–9: 24th annual meeting, American Academy of Dermatology, Palmer House, Chicago.

Dec. 11: Semi-annual seminar on Hepatic Pathology, Illinois Registry of Anatomic Pathology, Hektoen Institute for Medical Research, Chicago.

1966

Mar. 5–6: First National Congress on Medical Ethics and Professionalism, AMA-sponsored, Pick–Congress Hotel, Chicago. (Rescheduled from Oct. 2–3, 1965.)

Apr. 28–30: Midwest Conference on Anesthesiology, Illinois Society of Anesthesiologists, Continental Plaza Hotel, Chicago.

1965 **AMA**

Nov. 28–Dec. 1: AMA 19th clinical convention, Philadelphia, Pa.

1966

Feb. 4–9: AMA Medical Education Congress.

June 26–30: AMA Annual Convention, Chicago.

Nov. 27–30: AMA Clinical Convention, Las Vegas.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Wisconsin Psychiatric Association

The annual meeting of the Wisconsin Psychiatric Association will be held February 4–6 at The Abbey on Lake Geneva, Fontana. Theme of the meeting will be Psychiatry and Primary Prevention. Possible aspects of this subject to be discussed include: Psychiatric Health Values, Genetic and Psychosomatic Factors in Prevention, Learning from Special Child Rearing Experiences, The Psychiatrist and Education, and Practical Experiences in Primary Prevention. Dr. Herman P. Gladstone, Madison, is the program chairman.

Complete information will be given later. All reservations are to be made directly to the Executive Office at 756 N. Milwaukee Street, Milwaukee.

Congress on Medical Ethics, Chicago

The American Medical Association has rescheduled the First National Congress on Medical Ethics and Professionalism on March 5–6, 1963, at the Pick–Congress Hotel in Chicago. The Congress, originally scheduled October 2–3, 1965, had to be rescheduled because of a conflict with the Special Convention of the AMA's House of Delegates on those dates.

Any physician interested in attending the March Congress should write to James H. Berge, M.D., Chairman, Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, for detailed information.

Hepatic Pathology Seminar, Chicago

The Illinois Registry of Anatomic Pathology will present its first semi-annual seminar on Hepatic Pathology at 1 p.m. Saturday, December 11, at the Auditorium (first floor) of the Hektoen Institute for Medical Research, 627 South Wood, Chicago, Ill. The presentation will be made by Dr. Hans Popper, dean, Mt. Sinai Medical School and professor and chairman of the Department of Pathology, Mt. Sinai Hospital, New York.

Subscribers to the Registry will receive slides and transactions, and may bring their residents to the seminar. Non-subscribers may participate for a fee of $20, payable to the Illinois Registry of Anatomic Pathology. Apply to Paul B. Szanto, M.D., Registrar, Hektoen Institute, 627 South Wood, Chicago, Ill.

American Academy of Dermatology

The American Academy of Dermatology will hold its 24th annual meeting December 4–9 at the Palmer House in Chicago. The six-day annual meeting will open with two days of concentrated postgraduate courses each lasting 12 hours. Subjects include his-

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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MEDICAL MEETINGS *continued*

topathology, radiation therapy, fundamentals of cutaneous allergy and immunology, structure and function of the skin, cutaneous surgery, advances in biological sciences in relation to dermatology, carcinogenesis, percutaneous absorptions and microbiology. A total of 84 informal discussion groups with authorities on various aspects of dermatology are being scheduled throughout the meeting.

Further information may be obtained by contacting Stanley E. Huff, M.D., Academy Secretary–Treasurer and General Chairman of the Committee on Arrangements, 636 Church Street, Evanston, Ill.

Conference on Anesthesiology, Chicago

The third annual Midwest Conference on Anesthesiology will be held Apr. 28–30, 1966, at the Continental Plaza Hotel, Chicago. The meeting is sponsored by the Illinois Society of Anesthesiologisets. Members of the State Medical Society of Wisconsin have been extended an invitation to attend. For information contact: T. L. Ashcraft, M.D., General Chairman, 33 East Cedar St., Chicago, Ill. 60611.

Mt. Telemark Medical Symposium

The third annual Mt. Telemark Medical Symposium and Ski Outing, presented by the Indianhead Chapter of the Wisconsin Academy of General Practice, will be held Feb. 15–17, 1966, at Mt. Telemark Ski Chalet, Cable. All physicians are invited. There is no registration fee. The meeting is supported by a grant from Eli Lilly & Co.

A faculty from the Mayo Clinic will present a program on General Medicine each afternoon. There will be a "mixer" hour preceding dinner on two of the days. Daylight hours are reserved for skiing by the experts or the novice. All equipment can be rented.

For information concerning accommodations in the Mt. Telemark Ski Area, write directly to: Manager, Mt. Telemark Ski Area, Cable, Wis.; phone: area code 715–798–3311.

* * *

BETWEEN THE TIME of discovery in a research laboratory and the time when a drug finally is marketed, the average period has been five to six years.

* * *

SOME 850,000,000 prescriptions were written in the United States during 1963.

* * *

THERE WERE 43,999 medical articles on heart drugs published between 1931 and 1959.

OFFICIAL CALL
for Scientific Exhibits

1966 ANNUAL MEETING, LA CROSSE, MAY 9–10–11–12

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1966 Annual Meeting. The exhibits will be located in **Sawyer Auditorium, La Crosse.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1966 meeting are requested to file an application before Jan. 1, 1966, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Assignments made as exhibits approved by Commission on Scientific Medicine.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Brede Inc, Minneapolis on form to be furnished all exhibits scheduled)

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 4′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: JAN. 1, 1966.**
Address your communications to:

E. S. Gordon, M.D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison Wis. 53701

USE FORM ON OPPOSITE PAGE→

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBIT

1966 Annual Meeting La Crosse May 9–10–11–12

★

Fill out the following information and mail to:

E. S. GORDON, M. D., *Director of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. **Feet Required:** _____ **(In figuring feet required, remember the space is only 4′ deep, so your exhibit must be flush against the back wall.)**
   (Space is scarce so ***do not request more than is necessary****)*

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

DEADLINE: All applications must be filed by Jan. 1, 1966. Assignments made by Feb. 1.

the wisconsin medical journal

VOLUME 64/NUMBER 11 NOVEMBER 1965

The Place of Psycho-Active Drugs in Medical Practice

A SYMPOSIUM

Presented at the 123rd Annual Meeting of the State Medical Society of Wisconsin, May 12, 1964, Milwaukee, in cooperation with the Wisconsin Psychiatric Association.

Chairman: Milton H. Miller, M. D.

■ ONE OF THE MOST remarkable of the many remarkable developments in the recent decade of medical practice and research is the impact of the new psycho-active drugs. These new medications which so remarkably affect man's mood and manner have captured the attention not only of the medical profession but also of our society in general. They are utilized all over the world and in all, perhaps a hundred million people or more have received them from their doctors.

In this country, tranquilizer medications are now the third most common category of drugs dispensed by general practitioners. They constitute, along with sedatives, between 15 and 16 per cent of all prescriptions which are written. Following the introduction of chlorpromazine by Delay and Deniker in 1952, there has been a remarkable elaboration of hundreds of medications designed to reduce anxiety and generally provide a more comfortable emotional state for the patient. Although these medications differ greatly in terms of chemical structure and presumed mode and site of action, they are grouped together as "tranquilizers." In this symposium, we will focus upon the use of the tranquilizer medications.

On this panel four members of the State Medical Society of Wisconsin will discuss the use of these drugs in contemporary practice. One is Dr. Robert T. Urbanek of Beaver Dam, a general practitioner with a specific interest in work with psychiatric patients. The other three panelists are psychiatrists. They are: Dr. Earl H. Jochimsen from the Sheboygan Clinic, Dr. William L. Lorton, from the Milwaukee Psychiatric Hospital in Wauwatosa, and Dr. Gilbert B. Tybring, formerly clinical director of the Mendota State Hospital and now practicing in Madison.

THE USE OF PSYCHIATRIC DRUGS

R. E. Urbanek, M. D.

I would like to state first that I am a general practitioner with a special interest in emotional disorders. Having been in general practice and having two years experience in psychiatry before these medications were introduced, I am aware of their tremendous importance in office and local community hospital treatment.

There are many patients seen locally who benefit from psychotropic drugs and never find their way to a psychiatrist's office or psychiatric hospital. A large number of these people were making borderline adjustments or were actually "hidden" by their families before they became aware of the usefulness of these medications. Many postpartum and postoperative psychoses are being treated locally. Geriatric disorders have also been helped.

There are problems in using these drugs over and above their side reactions. Many

times we use them in doses that are small and ineffective. Sometimes we change medicines too quickly or sometimes we attempt to change the patient's moods by mixing the various types of drugs. I have seen patients taking as many as four or five psychotropic drugs. I feel this type of treatment would tend to complicate the difficulty rather than improve it.

With these problems on the physician's part, we must also consider that the patients may not follow directions. They become impatient. They may consult others at the same time.

Although we may be criticized for not using large enough doses, I think it is important to adhere fairly closely to the manufacturer's recommendations for office use of these drugs. Of course, at times, consultants do return a patient to us on doses greater than recommended or on combinations that ordinarily are not recommended. There are times when a patient does well on ward care while taking a combination of drugs, but when he is sent home to his daily routine, he may not function well at all.

There is one situation that applies not only to the psychiatric patient, but also to patients in general. There are patients who leave their community for care elsewhere. This is their privilege. I do feel, however, that the physician consulted should inquire as to what doctor would be called locally in case of emergency. When any dangerous drugs are prescribed, I feel someone locally should be available and have on record what has been done. Patients are reluctant to let their family doctor know they have consulted someone else, but it is certainly difficult to be called to see a comatose patient surrounded by several empty bottles and find the name of a physician 50 to 100 miles away.

Along this same line I think we should expect that any patient referred from a treatment center to a county guidance clinic should also have a summary sent to a local physician.

In summary, I feel these medications are of great importance in everyone's practice. They have their dangers, but so do almost all other drugs we prescribe. We must be aware of the drug's uses, its dangers, and the trustworthiness of the patient to whom we give it. Finally, if we see the patient is not improving within a reasonable time or it is difficult to maintain control, we should be honest with ourselves and our patients, and ask for more experienced and better supervised help.

Earl H. Jochimsen, M. D.

My particular interest in this subject is not especially in the use of the drugs, or in particular drugs, but rather the indications for using them. Since these medications have been introduced, their use has been phenomenal. As all of us know, they are useful beyond doubt, but also without question is the possibility of their misuse. I refer not to the dangers of these drugs in terms of side effects or harmful effects of the drugs themselves, but rather the danger of their use when other treatments are more appropriate.

It is my feeling that the greatest danger involved in all tranquilizers, or antidepressants, is their being viewed as the first line of defense in emotional problems. The use of drugs is not the ideal treatment for such conflicts, of which the varying complaints of anxiety, depression, psychophysiologic illnesses, and other symptoms are evidence. Rather, of course, resolution of the conflicts presenting such symptoms is the treatment of choice. As is known, not all patients are candidates for those therapies which aim at solutions of underlying problems, but such treatment should be uppermost in our minds when we consider possible treatment plans for emotional illnesses presented by our patients. After a diagnosis of such illness is made, the first attempt at treatment should be an effort to try to elicit such problems as may be present.

I would feel a psychiatric consultation is the first step in every case of emotional illness, regardless of its presenting symptoms. I fully realize this is not practical in all areas of this state, but it is the goal toward which we must aim. Psychiatrists should be able to determine in a consultation, or in some cases several interviews, what treatment program is best for each patient seen—whether this be an attempt at conflict resolution, treatment by drugs, changing of the environment, hospitalization, combinations of these, or other techniques. Once such a program of diagnosis and treatment is accomplished, the question of how much of which drug can be considered. As in all of medicine, we can help more patients and produce more lasting personality changes

when we see them early and set up the best treatment programs early in the course of the illness—just as in the treatment of cancer or pneumonia.

When psychiatric consultation is not readily available, a screening with this suggested intent should be done by whoever is available with the best experience in such matters. Such screening takes time, I realize, but there is no substitute for it. Attempt to help your patient discover the problems, and attempt to help them deal with those problems, as the treatment of choice. Then and only then, and only as a substitute for or in conjuncton with such treatment should drugs be used.

Once a drug management program is set up, continued attempts to understand the underlying conflicts should be maintained. Such patients should be seen regularly and doses prescribed only until the next visit, when further questioning about problems should occur, not just regarding symptomatology. As I often tell my group colleagues, if the choice comes between talking to the patient or spending the time writing prescriptions, choose the talking. Never underestimate the curative power of yourself, rather than your prescriptions.

Briefly regarding these drugs, I choose one in each category and familiarize myself with it and its precautions, and I would suggest the same for you. For the agitated psychotic, chlorpromazine hydrochloride (Thorazine) is my drug of choice, usually beginning intramuscularly in doses of 50 mg every four hours, watching blood pressure carefully during such administrations. Administration is later changed to oral at usually a slightly higher dose. When chlorpromazine cannot be used, thioridazine hydrochloride (Mellaril) is sometimes useful, although the only case of agranulocytosis I have seen in connection with phenothiazines has been with the use of this drug. Recently skin pigmentation and changes in the eye have been reported, but only in high doses given over long periods of time.

The other phenothiazine I use regularly is trifluoperazine (Stelazine) which has the advantage of little sedation, but disadvantage of unreliability in very disturbed patients. Its problem with extrapyramidal symptoms is well known and has been discussed.

The "mild group" of tranquilizers includes meprobamate (Miltown or Equanil) and chlordiazepoxide (Librium). Meprobamate is useful, especially when there is muscular tension although it makes people tired. As you know, it should not be withdrawn rapidly as convulsions have occurred, but I feel no potent drug should be rapidly withdrawn and this simply fits that general rule.

Chlordiazepoxide is a good drug, although not useful in the cases I usually see. It is very helpful for many people, however, especially with gastrointestinal complaints as evidence of their conflicts. I often add it to the phenothiazines when they alone do not relieve all symptoms and increasing the dose of phenothiazine produces sedation or other undesirable effects.

There is one other drug I have some sentiment about and this is glutethimide (Doriden). To me this is a very addictive and suicidal drug and I would not give it to patients inclined to either. While on this subject I might add that prolonged use of barbiturates for sleep should be used, if ever, only when a consultant has established this as the only possible way to treat such a patient. Again, solution to the problems causing such insomnia should be the treatment of choice.

All drugs mentioned should not be given in open prescription, but only enough to last until the next appointment. I never see any patients at intervals greater than two months, usually less, and then such drugs are given in two-or-three-week supplies with refills rather than one large supply. I feel you should refuse treatment to anyone who will not cooperate with such a program, as any compromise is not practicing proper medicine.

OFFICE AND HOSPITAL USE OF TRANQUILIZING DRUGS

William Lorton, M. D.

Most of my experience with the tranquilizing drugs has been in a private mental hospital with a population of seriously disturbed schizophrenics, depressions and character and behavior disorders including alcoholics and drug addicts. We have found these drugs to be of tremendous aid in the management, particularly of schizophrenics as well as in the other two categories, especially when an episode of acute agitation or panic occurs.

My main interest in these drugs and the focus of my remarks is their use in conjunc-

tion with and to actually facilitate the process of psychotherapy aiming toward a deeper understanding of the problems with attainment of increased self-control and self-esteem.

The basic idea I would like to convey is that when we prescribe these drugs, we should do it in such a way that the patients understand that although the drug may be of tremendous help, it is not the final answer which will bring about a solution to their problems. I have found that if one takes adequate time and pains to explain this, even to psychotic patients, they usually see the point and say something to the effect that they realize they can't take medicine the rest of their lives.

I feel that the drug should be looked on as a temporary help even though this may mean two, three or four years for a serious schizophrenic, until he can develop adequate understanding of his problems and his own inner controls. Even in a situation where psychiatric help will not be utilized, or for some reason is not available, it is well to point out to the patient that serious reflection on the problem, preferably with the guidance of a person skilled in counseling, is desirable. Failing this, at least urge them to keep as open a mind as possible and life itself may provide some corrective emotional experience which will help bring about an apparently spontaneous improvement and enable one to stop or at least reduce the dose of the drug. Prescribing drugs without this attitude of acceptance and emphasis on understanding may be taken by the patient as a rejection of himself and his problems and thereby only create additional problems.

Numerous placebo studies have demonstrated the enormous value which "something prescribed by the physician" has for the patient. We can also sabotage the potential usefulness of the drug by taking too casual an air about the way we prescribe it for example by pulling some old drug samples out of a box beneath the desk and saying, "Here's something that might help," without having detailed prescribing and dosage information at hand. This may lend such an air of haphazardness to it that much of the potential effectiveness may be lost. This is one of the reasons why it generally is best to have a certain small group of drugs that the clinician knows well so he can prescribe them with confidence and knowledge.

I would like to comment on the term "tranquilizing" since it is somewhat of a misnomer unless it is used in a stricter sense as discussed by Mortimer Ostow in his book, DRUGS IN PSYCHOANALYSIS AND PSYCHOTHERAPY. He looks upon the major tranquilizers represented by the phenothiazines and the rauwolfia derivatives as agents primarily to reduce the amount of instinctual energy flooding the disturbed patient whether he be very accelerated and overactive or retarded, inert and mute as some patients are in defending themselves against a plethora of overwhelming feelings. The same drug may be helpful to both types of patients, and thus it is evident that the term "tranquilizing" makes sense only if we think in terms not only of behavior and verbalizations but also of the level of the patient's inner psychic energies.

With this point of view the specific drug is not quite as important as the right group of drugs. The tranquilizers are often divided into the major and minor types and most of my experience has been with the major type which includes the numerous phenothiazine derivatives with chlorpromazine as the prototype. It is often implied that these drugs ("minor tranquilizers") are indicated in the neuroses and psychosomatic disorders and the major type in the psychoses. However, I don't feel this comparison is quite valid in that the phenothiazines seem to exert an antipsychotic effect in a rather basic way through their effect on the mid-brain reticular system, the hypothalamus and limbic system, with a considerable change or even disappearance of major psychotic symptoms, such as hallucinations, delusions and thinking disorders.

On the other hand, the evidence that the minor tranquilizers exert any basic effect on major neurotic symptoms or energy disturbances within, is much less definite. Certainly they may be very useful in alleviating the acute distress and anxiety, but I would strongly suggest that in using these drugs attempts be made to keep in regular contact with the patients, in order to support them, to observe the possible occurrence of any adverse side effects, to gradually taper off the drug under strict supervision so that dependence and withdrawal complications are avoided, and here I am talking chiefly about the minor tranquilizers in the neuroses.

Getting back to the use of major tranquilizers, I mentioned that they may have a rather basic effect on the energetics of the illness and produce rather startling improvements. In my opinion, this is no time to relax one's vigilance over these patients for the following reason. Attentive patient listening to these individuals often reveals that although they are superficially greatly improved, they are still struggling with enormous anxiety, conflicts, and bizarre thoughts. The alleviation of the acute terrifying psychotic symptoms may greatly improve their ability and desire to come to grips with the psychological roots of the problem and just because they have attained some superficial improvement is no reason to allow a chance for deeper understanding to slip by unnoticed.

For some time it was thought that with the improvement psychotics can obtain from tranquilizing drugs, this might lead to the development of a great deal of resistance in patients to taking an honest look at themselves psychotherapeutically. In my experience, this has not been true providing that adequate time and patience is taken in explaining their use and to work through their ideas and feelings about taking medication in the first place.

If one is faced with an acutely psychotic patient, Ostow's advice seems wise, that we do not give both a tranquilizer and an energizer initially. This confuses the picture and there is no way of adequately assessing what is helping or worsening the patient. In the case of an acutely disturbed hyperactive patient, it would seem to me better to err on the side of giving him a tranquilizer in order to facilitate his immediate management and hospitalization. If a patient is in a severe retarded depression, there is not going to be too much difficulty in getting him into the hospital in the first place.

When the indications are clear-cut, it doesn't seem to me that the adverse reactions are frequent or serious enough that one need be too cautious about giving an adequate dose of a tranquilizer. This, of course, is assuming that one has made sure previous medications had not been administered as all tranquilizing drugs greatly potentiate the effect of sedatives and alcohol. Ruling this possibility out, an unnecessarily small dose of the tranquilizer may be as dangerous as overdosage. As a matter of fact, the danger of overdosage, when properly supervised, is extremely remote.

There is some selection within the phenothiazines in that if the patient is acutely hyperactive and some sedative action is desired, it is better to pick one of the phenothiazines belonging to the dimethylaminopropyl group, which includes chlorpromazine, thioridazine, and promazine (Sparine). Drugs of the piperazine group, such, as trifluoperazine, prochlorperazine (Compazine), perphenazine (Trilafon), and fluphenazine (Prolixin), are extremely potent and useful in the treatment of schizophrenics but are probably better left to the psychiatrist who is handling them over a long period of time. They have little sedative action but are prone to precipitate extrapyramidal symptoms.

In brief summary, I think these phenothiazines are a remarkable group of drugs and would plead for using them in a way that does not sabotage either their effectiveness or the patient's chances for obtaining understanding, which we hope will lead them to the necessary inner controls so they can do without the drug.

PANEL: OFFICE AND HOSPITAL USE OF TRANQUILIZING DRUGS

Gilbert B. Tybring, M. D.

I have been asked by Doctor Miller, for the purposes of this discussion, to present my patterns of use of the tranquilizing drugs along with remarks which might be pertinent for other physicians using these medications. I will not discuss the antidepressant drugs, nor will I discuss the barbiturates or related drugs which fall into the category of sedatives and soporifics. The group of drugs referred to as tranquilizers is a group which shares properties in that they tend to relieve anxiety, tension, and the intensity of other emotional responses, at the same time having minimum sedative effect and causing little or no clouding of the sensorium. First, I would like to make a few remarks concerning the so-called minor tranquilizers and then focus the greater part of my discussion on the phenothiazines with attention to various subgroups and to related compounds.

By minor tranquilizers I refer to such compounds as meprobamate (Equanil, Miltown), chlordiazepoxide (Librium), di-

azepam (Valium), and the hydroxyzines (Atarax, Vistaril). I use the first three of these medications fairly frequently in my practice. In my very limited experiences with the hydroxyzines I have found them to have a very weak tranquilizing effect. My use of the minor tranquilizers is by and large as an adjunct to psychotherapy. Used judiciously, these preparations can be symptomatically helpful in intermittent anxiety reactions such as those characterized by hyperventilation attacks, and with the obsessive compulsive reactions. Some of these preparations, including meprobamate and particularly diazepam, have skeletal muscle relaxant properties and therefore are sometimes helpful with patients who present musculoskeletal somatization. Whenever these preparations are used over a moderate to extended period of time, there tends to be a weaning problem when the physician desires to discontinue medication. This must be dealt with in psychotherapy. With the possibility of this problem, this group of medications should be used particularly judiciously in patients where passive-dependency needs are prominent and regression to dependency on medication may easily develop.

These preparations, particularly with use of higher dosages, are apt to produce drowsiness and ataxia, or sometimes excitement. Toxicity is generally low although occasional toxic reactions include skin rash, gastrointestinal disturbances and rarely blood dyscrasias. Menstrual irregularities have been reported with chlordiazepoxide, and libido may sometimes be altered.

I believe that in our busy practice we sometimes tend to use these minor tranquilizers too widely and too loosely. They are often used in extreme tension states or borderline psychotic reactions where a phenothiazine would be much more appropriate. They are sometimes used for symptoms of depression where an antidepressant might more appropriately be used. As a word of caution, the action of preparations such as chlordiazepoxide can be prolonged over several hours. These preparations are sometimes potent sedatives, or infrequently elators. Further, patients taking these medications should be cautioned about an additive effect sometimes experienced by patients on medications who use alcoholic beverages, even in moderate amounts. With these preparations there would appear to be some tendency toward drug tolerance, and withdrawal symptoms are possible in patients who have been taking large doses.

The first effective tranquilizers were the rauwolfia alkaloids, particularly reserpine. As a group these preparations have also been widely used for their antihypertensive effect. These preparations tend to be hypotensive and depressive, sometimes reduce the seizure threshold, and share with the phenothiazines the annoying side effect of producing Parkinsonoid and other basal-ganglion symptomology.

The first phenothiazine tranquilizer to gain prominence, which followed shortly upon use of the rauwolfia compounds, was chlorpromazine, marketed in this country as Thorazine, but previously marketed in Europe and Canada as Largactil. Since introduction of chlorpromazine, because of its rapid, reliable effectiveness, psychiatric use of the rauwolfia alkaloids has gradually but steadily declined. Chlorpromazine remains the yardstick for measuring newer tranquilizers and many have fallen short.

Chlorpromazine is representative of a group of phenothiazines having a dimethyl side chain attached to the phenothiazine ring structure. This group also includes triflupromazine (Vesprin) and promazine (Sparine). Thioridazine (Mellaril), while having a piperidyl side chain rather than a dimethyl, has properties similar to this group and will be considered with the dimethyl compounds. These compounds have moderate sedative effect without clouding of sensorium and are very helpful for their calming effect in agitated, hostile, or otherwise over-active patients. They are useful in the hospital setting in treating negativism, catatonic and paranoid symptomology, and of crucial importance in long-term maintenance of the patient in partial or fairly complete remission of the community. I have also found these preparations very helpful in combination with an antidepressant for management of agitated depression and involutional paranoid reactions.

It is important that these drugs be used in dosage sufficient to bring about desired therapeutic effect. Aside from basal-ganglion symptomology these preparations are relatively nontoxic even in large doses. Sedative and tranquilizing effect tends to be dose related and it is often necessary to con-

trol Parkinsonian side effects by concomitant use of anti-Parkinsonian agents. Chlorpromazine is frequently used in the hospital setting in doses up to 2,000 mg per day and has been used up to 5,000 mg. In my office practice I have rarely had to use more than 800 mg per day for maintenance.

Dosage of thioridazine roughly parallels that of chlorpromazine and it is only slightly more sedative and slightly less effective. Extrapyramidal symptoms are less frequent with this preparation. Toxic retinitis has been reported with thioridazine in doses above 1,600 mg. Triflupromazine is reportedly effective although I have had little experience with this drug. Promazine is much less toxic but at the same time much less effective as a tranquilizer.

These preparations are chemically related to the antihistaminics and dryness of the mouth is a frequent annoying side effect. Other autonomic and endocrine side effects often encountered include stuffy nose, tachycardia, pallor, constipation, blurred vision, weight gain, edema, and occasional lactation or menstrual disturbances in women. Vivid dreams are occasionally annoying side effects. Seizures have been reported. With institution of therapy there may be a transient fever and eosinophilia during the first two or three days. Allergic manifestations include skin rash and infrequently an intrahepatic obstructive jaundice which clears within a period of days or weeks after discontinuation of the drug. A rare but serious complication is agranulocytosis. Patients taking chlorpromazine particularly are photosensitive and should be cautioned against exposure to bright sunlight in the summer months.

Another group of phenothiazines has come on the market in recent years and is characterized by a piperazine subgroup appended to the basic phenothiazine ring. Most members of this group are characterized by a much greater milligram potency with respect to tranquilizing effect and ability to induce basal-ganglion symptomology. They are less toxic in other ways such as sedative potential. The piperazine group includes fluphenazine (Prolixin, Permitil), trifluoperazine (Stelazine), perphenazine (Trilafon), prochlorperazine (Compazine), thiopropazate (Dartal), acetophenazine (Tindal), and carphenazine (Proketazine).

Perphenazine, thiopropazate and carphenazine have found favor in the psychiatric literature. I have found fluphenazine and particularly trifluoperazine to be most valuable adjuncts to our therapeutic armamentarium. These drugs are uniquely useful for psychotic patients where sedative, calming effect is not needed—the withdrawn apathetic patient. They are helpful in combating schizophrenic thought disorder. Like all phenothiazines, these preparations are nonaddicting. Because of their annoying side effects, patients look forward to the day when the medication can be discontinued and there are no withdrawal phenomena. I tend to use the latter two preparations widely as maintenance therapy for patients with anxiety-tension states or obsessive-compulsive, ruminative states. This use is as an adjunct to psychotherapy. I also use these preparations in combination with an antidepressant in many neurotic depressive reactions.

Side effects and toxic complications with compounds of the piperazine subgroup tend to parallel those of the other phenothiazines. Because of the lower milligram dosage, side effects and toxicity, with exception of extrapyramidal symptoms, tend to be much less frequent. I do caution patients that they may encounter drowsiness or postural hypotension during the first few days on medication or on an increased dosage schedule. With these more potent compounds dosage should begin at a level of 2 mg two or three times a day but may be carried gradually considerably above this if well tolerated. I once encountered a complication of severe wry neck in starting a patient on the 5-mg level of trifluoperazine.

With acute paranoid or schizophrenic psychotic states I frequently use fluphenazine or trifluoperazine in combination with chlorprothixine or thioridazine in dosage ratio of 1 to 25 or 1 to 50. I will then tend to use the same dosage ratio with lower total dosage for follow-up maintenance in the office. Combination of drugs in this manner would appear to make it possible to treat the patient in lower dosage ranges and accordingly with less side effects or toxicity.

Chlorprothixene (Taractan) is another tranquilizer on the market which is not a phenothiazine but which has a ring structure similar to the phenothiazine nucleus. Toxicity and side effects appear to be quite

similar to those of the phenothiazines. In my experience this medication is somewhat less effective than the phenothiazines in the major psychiatric disorders, but the drug is useful where allergic manifestations have been met with phenothiazine preparations.

It would be well, however, for the physician to have thorough knowledge of the therapeutic use and toxicity of one or two preparations from each major group. Where toxic or allergic effects are met with a drug from a particular phenothiazine subgroup, a similar preparation from another subgroup may be substituted. It is a good general principle to change medication occasionally if adequate therapeutic benefit is not being achieved. The guide rules for such changes are ill-defined at this point and the situation often becomes one of empirical experimentation until a given patient's responsiveness to a medication is found.

SUMMARY SECTION

Milton H. Miller, M. D.

Let me assume the chairman's prerogative of abstracting and summarizing very briefly certain of the cogent themes which have recurred through this series of interesting presentations. All of our panelists seem to agree that the tranquilizer medications are here to stay, that they represent important contributions to the armamentarium of the physician and that properly used, they offer to many patients a hitherto unavailable source of relief of symptoms and a chance for a much more comfortable and productive way of living. They seem well established as among the most effective chemotherapeutic agents in medicine and their emergence changes various aspects of the practice of the psychiatric specialist and the general physician as well.

Members of the panel were also unanimous in pointing out that emergence of the tranquilizer medications not only allows the doctor to assist in lowering the level of anxiety and agitation in certain patients but also opens the door to a much more meaningful, interpersonal psychotherapeutic relationship. In many instances these newer medications have provided the doctor with an even greater opportunity to move closer to his patients, to listen more meaningfully, and to offer understanding, encouragement, and assistance at the interpersonal level not previously possible.

As with most other medications, there is enormous variation among individual patients in terms of appropriate dosage, time of onset of symptom relief, drug specificity, and the like. Further, all the medications have side effects of one sort or another and patients require close supervision while under active care. Our speakers seem generally agreed that it is better and wiser for the physician to learn the indications and contraindications and side effects of a few of these medications rather than trying to master the ever-growing list of tranquilizers which are available on the market.

My own experience parallels that of our panelists in observing that a great many physicians use these medications in small homeopathic doses which render them ineffectual, or, that medications are given without the level of encouragement and supervision by the doctor which is so necessary in developing an effective therapeutic regimen. As with penicillin, digitalis, and the like, tranquilizer medications which rest in the bathroom cabinet do no good. Neither do half dosages or erratically ingested dosages.

It is important for the physician to communicate a great deal of information to the patient about the expected course of treatment including likely effects and mode of actions of these medications. I find that the more my patients know about the medications they are being instructed to take, the probabilities of their effectiveness, the possible side effects, and the availability of alternate medications if necessary, the more likely the therapy will be carried to an adequate conclusion.

The necessity for shading doses, for substituting one medication for another, the general level of irritability and uncertainty with which anxious patients begin any therapy, makes the necessity for "doctoring" and the art of medicine as important here as anywhere in the whole field.

In summary then, those of us on the panel feel that where properly prescribed, where administered in a doctor-patient atmosphere of candor, the tranquilizer medications may be wonderfully effective in providing the kind of relief for symptoms that is so very satisfying to doctor and patient alike.

Discharge and Readmission Rates in Schizophrenic Patients and Population Movement of Winnebago State Hospital

By H. ALFRED DENZEL, M. D., Winnebago, Wisconsin

■ PUBLIC INTEREST in psychiatric patients has been increasing steadily in the United States during the past 10 years, especially since the report of the Joint Commission of Mental Health was published in 1960. This has also been true in Wisconsin where a system of 37 county hospitals throughout the state never lead to the development of huge state hospitals, but distributes the approximately 13,000 mental patients more evenly.

On a national scale, 1955 marked the turning point from an ever-increasing number of psychiatric beds to a slow but sustained decrease thereafter so that the number of beds in city, county, and state hospitals fell from an all-time high of 558,900 in 1955 to 528,800 six years later.[1] Prior to 1955, the psychiatric bed capacity increased each year by 6,000 to 8,000 per year. This trend has continued for the United States as a whole, but the figures for Wisconsin show a significant downward trend only since 1962 (Table 1).[2,3] These Wisconsin figures run parallel to the resident population figures of Winnebago State Hospital (Fig 1).

While the reasons for the decrease of psychiatric bed capacity are not entirely clear, it appears that drug therapy alone is not the most significant factor.[4] We have used ataractic drugs in at least 50% of our patients since 1956 and over 75% of patients since 1958. More significantly, it has been recognized in this country that in the past far too many psychiatric patients have been hospitalized. While in the United States over 46% of the total hospital bed capacity in 1961 was taken up by psychiatric patients, the Soviet Union, for instance, used only 11% of its total bed capacity for mental patients.

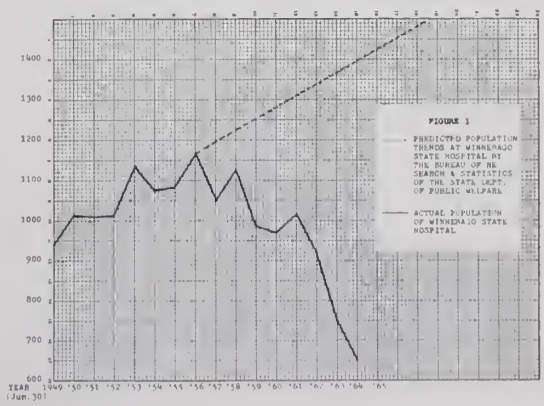
The total number of hospital beds per population was comparable to the number of hospital beds available in this country.[5] Placing the patient in the hospital is not only becoming increasingly expensive but also is handicapping the patient socially and psychologically. Recently therefore, alternatives to hospitalization, such as outpatient treatment, day hospital care, and other forms of ambulatory treatment, have been increasingly used in place of hospitalization.

At Winnebago State Hospital (W.S.H.) we reached our highest resident population in July 1961 (1,100) and the first significant decrease occurred in 1962.

Method and Material. This investigation was undertaken in order to obtain data that would make it possible to compare what happened to a patient in our hospital 50 years

TABLE 1—*Resident Populations in State and County Mental Hospitals as of June 30*

Year	Wisconsin[2]	U. S.[3]
1955	15,008	558,922
1956	15,083	551,390
1957	15,002	548,626
1958	14,930	545,182
1959	14,867	541,883
1960	14,959	535,540
1961	15,003	527,456
1962	14,071	515,640
1963	13,920	504,604
1964	13,600	490,754



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ago with the result of treatment given today. Due to the unavailability of accurate data and statistics for these earlier years, however, we had to confine our efforts to the past 24 years and only to one diagnostic category.

Since schizophrenia may be considered the most important mental illness in a state hospital setting, comprising presently 60% of all admissions and 50% of the hospital resident population at Winnebago State Hospital, this report deals only with this category. Also, it may be of interest to note that 75% of the 115,000 beds in the Veterans Administration mental hospitals in this country are occupied by patients suffering from schizophrenia.[6]

Schizophrenia is essentially a chronic psychosis and the prognosis usually becomes worse with time albeit not inevitably leading to dementia as was implied in the former term dementia praecox. For this reason, it was decided to separate schizophrenic patients into those entering the hospital for the first time (first admission) and all others that had been admitted to W.S. H. previously (readmission). We were unable to consider admissions to other psychiatric hospitals.

The diagnostic admission and discharge data was obtained by actual examination of the patient's hospital chart. Because of the sheer number of patients involved, we arbitrarily chose the months of January and June as a sample for the whole year. All other data was extracted from regularly compiled hospital statistics. From all these statistics, tentative answers to the following questions were sought through this investigation.

(1) Are there presently more or less schizophrenic patients in the hospital as compared to 1940, 1950, or 1960?
(2) Has the percentage of schizophrenic admissions of total admissions increased or decreased since 1940?
(3) How soon were schizophrenic patients discharged in 1963 as compared to earlier years?
(4) Does the suspected increase in early discharge rates seem worthwhile, or are patients returning to the hospital soon after their release?
(5) What are the reasons for the suspected change in hospital statistics? Isolate certain variables that may be studied in future investigations as to their potential influence on admission and discharge rates.

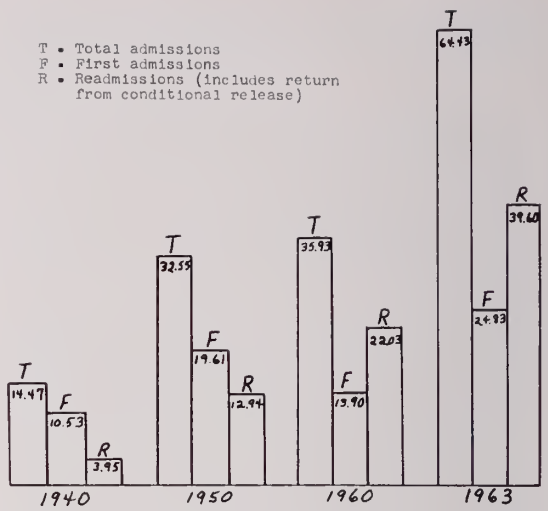

Fig. 2—Percentage of schizophrenic admissions of total admissions in the months of January and June, Winnebago State Hospital.

Results. Combined figures were tabulated for January and June 1940 through 1963 for schizophrenic first admissions and readmissions.* Figure 2 graphically presents the percentage of schizophrenic admissions of total admissions.

From these tabulations the following facts emerge:

A. ADMISSIONS

(1) There has been a steady increase in schizophrenic admissions. The total number of schizophrenic first admissions and readmissions for January and June 1940 was 22. This figure had risen to 118 for schizophrenic admissions in January and June 1963, or more than a five-fold increase.
(2) This increase in schizophrenic admissions occurred in both the first admissions and readmissions. The larger increase, however, occurred in the readmissions which rose from 6 admissions in January and June 1940 to 74 in 1963, or a twelve-fold increase as opposed to the first admissions which rose from 16 to 44, or about a two and one-half-fold increase. Total admissions to W.S.H. during this same period rose from 152 in 1940 to 298 in 1963. This increase roughly parallels the increase of first admission schizophrenics.
(3) From the above data, one can see that the real increase in schizophrenics occurred in the schizophrenic readmissions and is mostly

* These tabulated figures are available upon request to the JOURNAL.

due to the fact that more patients were discharged from the hospital and much sooner than previously. As a result of this, the percentage of schizophrenics of total admissions has risen from a low of 14.47% in 1940 to a high of 64.43% in 1963 (Fig 2). This makes schizophrenia the largest diagnostic category of all admissions to W.S.H. in 1963.

B. DISCHARGE

(1) In 1940 no patient was discharged from the hospital within four months and only 4, or 25%, of the first admission schizophrenics left within one year.

(2) In 1950, 14% of the first admission schizophrenics were discharged within three months, 38% within six months, and 62% within one year. Only 3, or 11.76%, of those patients discharged were readmitted within one year, which represents a very low percentage.

(3) In 1960 first admission discharges reached 48.72% within three months and 69.23% within six months. There was a parallel increase also in the discharge of readmission schizophrenics, which amounted to 42.86% within three months and 58.73% within six months. As would be expected with the increased discharge rate, more patients had to return to the hospital than in previous years. Consequently, 42.42% of the first admissions and 45.10% of the readmission schizophrenics had to return to the hospital within one year.

(4) The last set of data in this study concerns discharge data during January and June 1963. The discharge of first admission schizophrenics reached an all-time high amounting to 61.36% within three months, 72.73% within six months, and 81.82% within one year. Despite this large increase in early discharge, only 6 patients, or 16.67%, had to return to the hospital within three months and 3, or 25%, within one year. This represents a very significant decrease when compared with the figures of 1960 as given above.

(5) The figures for schizophrenic readmissions in 1963 are comparable to those obtained in 1960, showing a slight decrease from 65.08% for 1960 to 57.75% within one year for 1963. Of the 46 patients readmitted during January and June 1963, 8, or 41%, were again readmitted within one year. Due to the fact that more schizophrenic patients were discharged and more patients were readmitted, the increased chronicity of the patients was expected to show some decrease in discharge rate which, however, actually was very small. This probably means that many chronic schizophrenics still have a chance of leaving the hospital even though they have to return periodically.

(6) Since the hospital was able to discharge patients much sooner than in earlier years and the readmission rate, despite the increased discharge, remained favorable, the first significant decrease in hospital resident population in the history of W.S.H. occurred in 1962, and this trend continued into 1963 and 1964 (Fig 1). Due to the fact that the hospital population had increased every year, the Wisconsin Bureau of Statistics predicted that the resident population of W.S.H. would rise to about 1,400 by 1965. However, the actual resident population currently is below 700 (Fig 1).

Comment. While nobody can evaluate with certainty all the factors that contributed to the improved discharge rate and the decreased patient population, the following interpretation is offered for the changes that occurred at Winnebago State Hospital.

(1) Improved discharge rates antedate the arrival of the ataractic drugs at W.S.H. This early change reflected in the 1950 figures probably represents a more optimistic outlook for all mental patients.

(2) This therapeutic enthusiasm was greatly enlarged after the arrival of the tranquilizers, adding to the strides already made earlier.

(3) The really significant advance that lead to the decrease of hospital resident population from 1,100 to less than 700 within three years between 1961 and 1964 was probably achieved by:

(a) The adoption of an early discharge policy in the belief that cure of the large majority of schizophrenic patients is not possible and that most patients do as well or better at home than in the hospital.

(b) The active recruitment of psychiatrists increased the number of trained psychiatrists at W.S.H. from 2 in 1960 to 10 in 1964.

(c) The more active and effective use of drug therapy and outpatient therapy made early discharge more feasible.

Summary. Data are presented from hospital statistics showing:

(1) Improved discharge rates for first admission and readmission schizophrenics between 1940 and 1963.

(2) Decrease of resident population of about 40% between 1961 and 1964.

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Chlordiazepoxide (Librium) Compared with Meprobamate and Promazine (Prozine) for the Withdrawal Symptoms of Acute Alcoholism

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■ THE FAMILIAR symptoms associated with alcohol withdrawal, if inadequately treated, can prove incapacitating over an unnecessarily long period of time. Our private patients, exclusively men, receive a treatment which enables them to begin participating as soon as possible in a long-range rehabilitation program. Their usual stay at this treatment center is three weeks, during which time they are intensively indoctrinated in the program of Alcoholics Anonymous (A.A.) As consultants, we supervise the medical management of the alcohol detoxication period and provide any other needed medical service. At the end of their stay, these men return to their regular employment—most are in business or in the professions—and many are persuaded to continue with A.A.

During the past four years we have routinely employed a regimen which we consider most satisfactory for control of the severe central nervous system reactions occurring during the withdrawal phase. On admission, for combating acute agitation, the patient is given an intramuscular injection of a combination of promazine and promethazine (Sparine–Phenergan injection). He usually responds by becoming quiet and manageable, and often by sleeping for several hours. His subsequent medication, administered as needed, is an oral combination of meprobamate and promazine (Prozine), two tranquilizing agents which act upon separate areas of the central nervous system (the thalamic and the hypothalamic, respectively[1–3]) and which, together, produce quiescence without motor depression. With this regimen, we usually have been able to return our patients to the A.A. program in a matter of days.

Recently several investigators[4–9] have reported impressive results with chlordiazepoxide (Librium) in the treatment of the alcoholic withdrawal syndrome. In order to continue giving our patients the best available treatment, we decided to compare Librium with Prozine for effectiveness in the management of withdrawal symptoms.

Scope and Method. Our initial plan called for a double-blind, controlled evaluation of the two agents, carried out only in patients who had ingested large amounts of alcohol during the previous 24 hours and who had been given the Sparine–Phenergan injection. The patients were randomly assigned to Librium, Prozine, or placebo after agitation was controlled. Those who received placebos, however, tended to remain unmanageable and were easily distinguished

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This study was conducted at The Hazelden Foundation, Center City, Minn., by the medical staff of the St. Croix Falls Clinic.

from those who had been given active medications. They were then transferred to a known active medication (Prozine) and the control group was thereby largely lost. Furthermore, the first seven patients in the Librium group, who had been administered 50 mg of the drug four times daily, were stuporous. Reduction of Librium to half this dose corrected the condition, but meanwhile the identity of the medications had been disclosed. As a result, the study was redesigned as a direct comparison of the two active medications.

When it was terminated, the study consisted of a total of 70 men, 29 of whom had been treated exclusively with Prozine (patients who transferred from placebo were not included), 28 of whom had been treated with Librium, and 13 of whom had been retained on placebo because of some degree of positive response. Only patients treated and evaluated over a full four-day period were included in the final series. From an original Librium group of 32, four were lost to evaluation during the study, two having been hospitalized (one with fever and one with probable delirium tremens) and two having voluntarily withdrawn from treatment after one or two days. In the Prozine group, four of the original 33 also were lost; however, three of the latter were judged to be in satisfactory condition before the four days had elapsed and had requested discontinuation of therapy. The remaining patient was hospitalized because of extreme weakness (not a result of medication).

On admission patients were vigorously treated to control agitation and combat possible delirium tremens. The initial injection consisted in all cases of 50 mg of Phenergan, but the usual dose of 100 mg of Sparine was varied upward to 150 mg or downward to 50 mg depending on age, weight, and degree of agitation. The injection was repeated in several patients in whom agitation was not controlled by one dose or in whom it later returned. If admission was at night (the usual event), one of the oral regimens, chosen randomly, was started the following morning. If admission was during the daytime (which seldom occurred), the patient was handled the same way except that a decision had to be made whether to begin the oral regimen the same day or the following morning; most patients sleep for a considerable period after the Sparine–Phenergan injection.

TABLE 1—*Frequency of Administration of Hypnotics and Anticonvulsants to Patients in the Study*

	Placebo Group (13)	Chlordiazepoxide (Librium) Group (28)	Meprobamate-Promazine (Prozine) Group (29)
Phenobarbital sodium (Luminal)	----		1
Diphenylhydantoin sodium (Dilantin)	1	6	2
Mephobarbital	1	5	1
Chloral hydrate (CH)	1	5	5
Number of CH doses (1 gm/dose)	1	13	10
Number receiving second promazine-promethazine (Sparine-Phenergan) injections	1		3

The study drugs were administered in identical capsules. The Prozine capsules, two of which were administered four times daily during the waking hours, each contained 200 mg of meprobamate and 25 mg of promazine hydrochloride. The first seven patients in the Librium series received two capsules four times a day, each containing 25 mg of chlordiazepoxide, but the remaining patients (21) received only one Librium capsule along with one placebo capsule. The placebo group received two capsules of inactive materials four times daily.

Other types of therapy were held to the essential minimum. Standard measures were carried out for the treatment of dehydration, malnutrition, and avitaminosis. Chloral hydrate, diphenylhydantoin sodium (Dilantin), mephobarbital, and phenobarbital sodium (Luminal) were administered when deemed necessary. Chloral hydrate, 1 gm, was added at bedtime as a nocturnal sedative for patients who required extra sedation. Dilantin sodium and the barbiturates were administered only when convulsions were regarded as imminent. Table 1 shows the frequency of administration of these medications. After the initial four-day period all forms of medication were withdrawn from most patients.

The group characteristics were quite similar. The overall age range was 24 to 73 years, the mean ages being 46 years for the Librium series, 48 years for the placebo series, and 49 years for the Prozine series. In all there were 19 professional men, including physicians, dentists, a judge, an attorney, a pharmacist, several engineers, a clergyman, a research chemist, and a college professor. Many patients were businessmen and several were owners of their own en-

TABLE 2—*Condition on Arrival of Patients in the Three Groups*

	Placebo Group (13)	Librium Group (28)	Prozine Group (29)
Sober	5	4	8
Slightly intoxicated	4	8	4
Intoxicated	4	10	10
Very intoxicated		4	3
Nervous, agitated			1
Sobriety questionable		2	3

terprises. Most were intoxicated on admission (Table 2).

Evaluation of improvement during alcohol withdrawal presents many problems. Most patients spontaneously recover in a few days unless delirium tremens supervenes. Since most of the symptoms of withdrawal are subjective or have a strong subjective component, we chose to allow our patients to rate their own progress under guidance of the clinical psychologist, a member of the treatment center's staff. Initial self-rating was sometimes impossible, and evaluations were then made entirely by the professional staff.

Seven parameters were listed for evaluation. The selection was based solidly upon our past experience with acute alcoholism; we have noted that certain objective and subjective variables can be measured with a fair degree of validity and others cannot. We have also studied the difficulties that other investigators have had in evaluating drug-induced changes in the acute alcoholic syndrome and have concluded that certain aspects cannot be rationally measured. Anxiety, for example, is difficult to recognize in the inebriate. Although it undoubtedly appears during the withdrawal phase, there is little possibility of judging whether it has been ameliorated by medication; rest, the withdrawal of alcohol, and the institution of other badly needed therapeutic measures all must make important contributions toward the natural subsidence of such a symptom. The same is true for depression, "nervousness," excitation, or "restlessness." But other symptoms, such as loss of coordination, tend to persist in spite of rest, rehydration, and forced feedings, and are sufficiently reliable to serve as parameters for evaluating response to drugs. Our patients were rated in several such areas.

Each day an estimate was made as to whether the patient's appetite, coordination and orientation had been *excellent, fair,* or *poor,* and whether he had had *severe, occasional,* or *no* tremors, drowsiness, nausea, or weakness. For purpose of later analysis, the *no* responses were inverted to *excellent,* the *occasional* to *fair* and the *severe* to *poor.*

TABLE 3—*Total Response (Composite*) in Terms of Patients' Ratings on Each of Four Days*

	Placebo Group (13)†	Librium Group (28)	Prozine Group (29)
First Day			
Excellent	31	32	31
Fair	40	71	94
Poor	20	93	78
Second Day			
Excellent	47	54	74
Fair	38	94	104
Poor	6	48	25
Third Day			
Excellent	61	88	131
Fair	22	85	67
Poor	8	23	5
Fourth Day			
Excellent	64	105	159
Fair	19	76	42
Poor	8	15	2

*The group totals for each day represent the number of patients in the group multiplied by 7, the number of parameters evaluated. These parameters were appetite, coordination, orientation, tremors, drowsiness, nausea, and weakness (see text).

†The original placebo series was 34, but only 13 responded sufficiently to allow continued placebo therapy.

Results. By every indication—especially in the necessity of transferring placebo patients to Prozine, in the better early participation of the Prozine patients in the A.A. meetings, and in the clinical impressions of the attending physicians—Prozine was the more effective medication. Its superiority was also manifest, though to a lesser extent, in the patients' self-ratings. The latter evaluations are, however, the most practical way in which the comparison can be presented in this report.

Table 3 shows the total number of *excellent, fair* and *poor* responses in all parameters for the three treatments on each of four successive days. It can be seen that by the fourth day Prozine has firmly established its superiority over Librium. The superiority is all the more remarkable considering that the scores of the three patients who improved rapidly and discontinued therapy voluntarily before the end of the four-day period of therapy have not been tabulated. Obviously the placebo response cannot be seriously compared with the others, since the 13 placebo responders represent much less than half the original number of patients given placebos.

In order to compare patient progress more graphically, a system of scoring was devised

TABLE 4—*Mean Scores for Librium and Prozine on Each of Four Days*

	First Day	Second Day	Third Day	Fourth Day
Librium	1.69	2.03	2.33	2.46
Prozine	1.77	2.24	2.62	2.77

in which an arbitrary value of 3.00 was assigned to judgments of *excellent*, 2.00 to *fair* and 1.00 to *poor*. The ratings of Table 3 were thus converted to mean scores for either treatment on each of four days. Originally this had been done for all three treatments, but when the number of placebo patients who were subsequently transferred to Prozine became known, the placebo group was discarded for purposes of comparison. Table 4 presents the mean scores for Librium and Prozine. Note that there is less difference between them the first day than at any later time. When tested by chi square, the difference between Librium and Prozine was not significant the first day but was highly significant ($p < .001$) thereafter.

Side Effects. The restlessness, tremors, and other symptoms of withdrawal that persisted in the placebo series were scarcely side effects so much as they were evidence that the treatment was not giving relief. Two patients taking placebos developed convulsions in spite of barbiturate and Dilantin Sodium administration. In the Librium series, there were nine instances of side effects in seven patients: two instances of excessive drowsiness, two of gastrointestinal upset accompanied by anorexia, one of extreme restlessness, two of weakness (only questionably attributable to drug action), and two complaints of conditions described by the patients themselves as "goofiness" or "dopiness." Ataxia, a frequently found side effect of Librium therapy, either did not occur or was unrecognizable within the symptomatic framework of the alcohol withdrawal syndrome. Convulsions did not occur, perhaps because of the greater amount of Dilantin Sodium used in this group (see Table 1). In the Prozine series, two patients developed seizures in spite of treatment, but other "side effects" were merely a continuation of the withdrawal syndrome: "shakiness" in two patients and "nervousness" in two. One patient was hospitalized for severe weakness unrelated to the medication.

Comment. Disagreement with the general opinion that Librium is effective in the acute alcoholic state has been rare. Pennington,[10] in "drying out" alcoholics in preparation for long-term treatment, noted that meprobamate was more effective than chlordiazepoxide and had fewer side effects. As high as 13 per cent of patients on the latter compound had side reactions (dizziness, ataxia, blurred vision, and vomiting), 7 per cent being so severely affected that medication had to be discontinued.

Most of those praising Librium for its repression of withdrawal symptoms have done so even while admitting to a rather high incidence of side reactions. Rosenfeld,[6] administering the compound initially in high parenteral doses and following up with oral doses, observed a curious ankle edema that responded to diuretics. He also reported vomiting (responsive to chlorpromazine), drowsiness, grogginess, and ataxia. In a study of D'Agostino and Schultz[7] carried out in 300 patients at a large metropolitan hospital, 18 per cent developed ataxia despite a reduction of oral medication to 25 mg on the second day. Morrison[8] gave 168 acutely alcoholic patients 100 mg of Librium at admission, mostly by intramuscular injection, and followed up with oral Librium, 200 mg or more the first day and 40 mg on subsequent days. Although results were almost always good, side reactions (ataxia, vertigo, drowsiness, headache, constipation, nausea, and vomiting) occurred in about 10 per cent.

In our hands Librium performed in a nearly opposite manner to what we had expected. We had anticipated troublesome side effects but had thought they would be tolerable to our patients if the compound helped them through the uncomfortable and hazardous withdrawal period. Instead, we found relatively few side effects but much less relief than we had expected.

Our study has convinced us that Prozine is still the drug of choice for the withdrawal phase of acute alcoholism. Both medications are undoubtedly superior to placebo. The question as to whether some intermediate dose of Librium (perhaps 35 mg) would have equalled Prozine in efficacy was partially answered for us by the seven patients who received the higher dose; their mean score was even lower than for the remainder of the Librium series.

Summary. In a private clinc, Librium was compared with Prozine for the control of acute central nervous system symptoms during the withdrawal phase of acute alcoholism. The patients, all men of high occupational status, rated their own condition under professional supervision on each of four days with respect to appetite, coordination, orientation, tremors, drowsiness, nausea, and weakness. A placebo series of 34 patients was lost when 19 had to be transferred to Prozine and two more refused any further medication. The dosage of Librium had to be halved after seven patients on high (200 mg per day) dosage became stuporous. At termination the experiment comprised 70 men, 29 of whom had been treated exclusively with Prozine, 28 with Librium, and only 13 with placebos.

Comparison of responses showed that while both agents are far superior to placebo, Prozine remains the drug of choice in this application. Although Librium caused fewer side effects than had been anticipated, it was also less effective.

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Massive Glutethimide (Doriden) Intoxication; Successful Treatment with Dialysis

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■ GLUTETHIMIDE (Doriden) was first introduced in 1945. Its purpose was to provide a substitute for the barbiturates with all of the latters' advantages but free from their side effects. Its use as a preoperative sedative in children and adults, as well as its use in early labor, has found moderate acceptance. However, it has found its greatest usage as a tranquilizer for disturbed patients of all ages.[1] The extent to which tranquilizers are being utilized in the current practice of medicine is illustrated by the fact that in 1958 over 15 million prescriptions were written for these in the United States.[2] Of the drugs prescribed for this purpose, second to the barbiturates, glutethimide is most often used. It is the purpose of this article not to discredit this drug, but merely to present some of its toxicology and to caution physicians against writing prescriptions for large amounts of this (or any other) potentially lethal drug.

Chemistry and Physiology. Glutethimide is 2-ethyl-2 phenylglutarimide. It is poorly soluble in water and freely soluble in alcohol. Its method of elimination is not clearly understood, but it is believed to be excreted by the liver, absorbed in the gastrointestinal tract and reexcreted as a metabolite in the

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urine. However, absorption varies markedly as is witnessed by the recovery of an undissolved tablet 96 hours after ingestion. Following alcoholic ingestion, absorption is much more rapid. Prolonged usage may lead to addiction.[3]

Dosage. Therapeutic dosage varies from 0.25 to 1.5 gm per day. Toxic doses may result in coma. This has been reported following ingestion of as little as 10 to 15 gm. Death has been reported[4] following ingestion of 13 gm without adequate countertherapy. The minimum lethal dose is estimated to be from 10 to 20 gm. Recovery after ingestion of 42.5 gm has been reported. Thus it becomes clear that the toxic dose varies greatly and the outcome is largely determined by the rapidity and adequacy of treatment.

Diagnosis and Treatment. Mild cases of glutethimide intoxication are characterized by normal blood pressure, presence of deep tendon reflexes, and minimal disturbances of respiratory minute volume. The treatment is symptomatic. The dose was usually under 5 gm.

Severe cases manifest early hypotension and shallow or abdominal breathing which may lapse into apnea many hours after the ingestion of the drug. The response to stimuli varies with the depth of coma.

Treatment

1. Since the individual is in a varying degree of coma, his airway is of utmost importance. Endotracheal intubation or tracheostomy should be immediately available both to facilitate respiration and to avoid dangers of aspiration. There should also be immediately available either manual or mechanical methods for assisting faulty or absent respirations.
2. Blood pressure must be maintained in order to continue renal blood flow and to preserve the integrity of the kidney. Vasoconstrictors such as *l*-arterenol (Levophed) or metaraminol (Aramine) may be necessary.
3. Gastric lavage with water or saline.
4. Urinary output should be carefully checked. Fluid intake should not exceed 1500 ml per day.

Subsequent Therapy

If the degree of physiological depression increases or remains stationary for over 24 hours, the use of hemodialysis has been found most effective. Sheppard et al[4] devised a colorimetric method of determining the concentration of a metabolite of glutethimide in the blood and urine. Kier,[5] utilizing this method, found that urine levels of 4.4 to 5.8 mg/100 ml would result in patient recovery whereas a concentration of 39.5 mg/100 ml was the average found in four patients who failed to recover. Significantly, these substances were removed by dialysis at a rate of 100 to 400 times that of the kidney's ability to excrete them. Since these determinations are not readily available in most laboratories, and since the degree of coma is not directly proportional to the concentration of the drug, one must usually depend on his observation of the clinical progress of the patient whether to employ dialysis.

Stimulants. The use of respiratory stimulants such as bemegride (Megimide) or ethamivan (Emivan) in doses of 50 mg every 15 minutes up to 1500 mg is enthusiastically supported by some and as vigorously condemned by others.

Case Report. A 51-year-old woman was known to have had in her possession a bottle containing 100 tablets of glutethimide, a total of 50 gm. She was admitted to the hospital at 1:10 PM approximately 35 minutes after ingesting all but 10 of these tablets, a total of 45 gm of glutethimide. On admission her blood pressure was 56/48 mm Hg and her respirations 44. She had no deep tendon reflexes, was comatose, and was moderately cyanotic.

A Levin tube was inserted, an oropharyngeal airway placed in the mouth, and oxygen given by nasal catheter. Gastric lavage was carried out with tap water until clear. One undissolved tablet was found in the mouth several hours after admission. A urinary catheter was inserted. Blood pressure remained below 60 systolic until 6:30 PM but urine output continued. During this period repeated doses of ethamivan to a total dosage of 1000 mg were administered intravenously. This initially improved the depth of respirations. However, repeated doses became less effective and by 7:00 PM respirations had ceased. Blood pressure at this time was 74/54. A tracheostomy was performed and the blood pressure ranged between 60/40 to 68/50 mm Hg. An additional 300 mg of ethamivan was administered without effect.

Urinary output continued but in decreasing amounts. Administration of 8 mg of *l*-arterenol in a solution of 1000 ml 5% glucose was begun at 1:25 AM at an initial flow of 10 drops per minute. By 7:00 AM the pressure had risen to 92/52 mm Hg. The *l*-arterenol was gradually discontinued over the following three and one-half hours and the blood pressure remained more than 80 systolic. Pupils remained in mid-dilatation and did not react to light. There were no changes in the patient's reflexes as the day progressed and the apnea persisted. Ventilation was completely controlled. The patient was somewhat hyperventilated, thus keeping her slightly alkalotic rather than acidotic.

The laboratory results 20 hours after ingestion were: white blood cell count 16,400/cu mm; hemoglobin level 9.4 gm/100 ml; carbon dioxide content 18.5, chloride 73, potassium 3.8, and sodium 116 mEq/L. Because of the low blood carbon dioxide, at 4:00 PM the ventilator was discontinued for several minutes. This did not initiate respirations.

Spastic movements resembling hiccoughs occurred about every 30 minutes. Another 300 mg of ethamivan was administered without effect. The temperature had now risen to 101 F. It became apparent that unless the glutethimide concentration in the patient's blood stream was immediately lowered, she might well succumb to intercurrent pulmonary infection before adequate physiological lowering of concentration could be obtained. Accordingly, it was decided to transfer her to another hospital where the specialized technique of extracorporeal hemodialysis would be immediately available. Since a cuffed tracheostomy tube was not immediately available, a cuffed endotracheal tube was substituted for the tracheostomy tube, and, under manual artificial respiration, the patient was moved by ambulance without incident. The carbon dioxide level on arrival was 20 mEq/L. Since no improvement was noted, it was deemed advisable to dialyze the patient at once. Hemodialysis with the Kolff twin-coil artificial kidney was performed that night.

The following day, 48 hours after ingestion and in spite of the administration of 1450 mg of bemegride, complete apnea persisted. The patient was maintained on a Bennett respirator. Her temperature had risen to 102 F. The patient was redialyzed the following night and shortly thereafter feeble, but visible, spontaneous respirations occurred. These steadily improved so that on the morning of the third day it was possible to remove the endotracheal tube and reinsert the tracheostomy tube, allowing the patient to breathe without assistance. Her improvement continued rapidly and on the morning of the fourth day the patient was alert and could answer questions. The Levin tube was removed and the patient recovered rapidly, being dismissed under psychiatric care on the tenth day following the ingestion. The patient has since made a complete recovery without evidence of depression.

Summary. The chemistry, physiology, and methods of treatment of glutethimide (Doriden) intoxication have been reviewed. A case history of massive intoxication with recovery has been presented. It would seem evident that toxicity from this drug may occur with doses as small as 5 gm. Recovery from massive dosage can be achieved only by rapid, effective therapy. The use of stimulants is still questionable. It would appear at present that the most gratifying results are obtained when efforts are made to decrease the amount of glutethimide in the blood by utilizing dialysis. This case illustrates the gratifying result of teamwork between groups of physicians who combine their skills with good equipment to effect a cure in an instance where death seemed inevitable.

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Surgical GRAND ROUNDS NO. 2 OF A SERIES

UNIVERSITY OF WISCONSIN MEDICAL CENTER

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Surgical Grand Rounds are conducted weekly as a portion of the University of Wisconsin Medical Center program in surgical education. This conference is held at 4 PM on Wednesdays in Room 300, University Hospitals, and guest physician participation is invited. Cases presented at the Grand Rounds will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

DIAPHRAGMATIC HERNIA

Case Presentation.* *Dr. Timothy J. Donovan:* This 27-year-old white woman was referred to the hospital for evaluation of a left diaphragmatic hernia. Three weeks prior to this admission, she was playfully thrown into a swimming pool following which she noticed severe left anterior chest, shoulder, and neck pain. This was associated with tachypnea, diaphoresis, and weakness. The symptoms were of very brief duration, and the patient was entirely asymptomatic until the day prior to admission.

She again was involved in strenuous activity and suffered chest pain on the left side and shortness of breath. She saw her local physician who noted a gas-filled viscus in the left hemithorax on x-ray examination. Upon admission here, x-ray and physical examinations confirmed the presence of a left-sided diaphragmatic hernia with abdominal visceral contents in the pleural cavity. She underwent a thoracotomy at which time a 10-x-7-cm rent in the posterolateral part of the diaphragm was found and the stomach, transverse colon, mesentery and spleen were within the left side of the thorax. There were also some pleural adhesions present. It was felt that this patient probably had a small congenital hernia through which abdominal contents were forced when the patient was thrown into the swimming pool.

Discussion. *Dr. David Fink:* This is an interesting problem and the literature mentions numerous similar cases attributed to accidents involving trauma to the lower thorax or the upper abdomen. Traumatic diaphragmatic hernias were first described in the 1500s by Ambroise Paré. Two interesting cases which he described were war injuries to the diaphragm. The first was a man who was stabbed in the abdomen and who died three days later. When an autopsy was performed, the abdominal contents were found in the thorax. The second patient was an artillery captain who was shot through the chest but who lived for 15 months subsequent to his injury. During this interval he had had persistent nausea, vomiting, and marked weight loss. At the time of the postmortem examination, a herniation of the transverse colon was found through a thumb-sized rent in the diaphragm. These cases represent two of the characteristic clinical pictures associated with a rupture of the diaphragm.

To better understand diaphragmatic hernias, both congenital and traumatic, it is important to review the basic anatomy of the diaphragm. This muscular organ is dome-shaped, and is composed of several contributing muscular bands. It attaches anteriorly to the sternum with two muscular straps from the posterior aspect of the xiphoid process. Laterally and inferiorly, the lower six costal margins serve as the insertion for the muscles which interdigitate with the transversus abdominis muscle. From the lumbar area arise the crura, from the right and left side of the vertebral column. These muscular bands measuring 8 to 9 mm in thickness all converge to insert into a central tendon which is quite thin. Its average thickness is approximately 3 to 4 mm.

There are several natural foramina in the diaphragm and through which major structures pass. The aortic hiatus, which is actually retrodiaphragmatic, transmits the aorta, the azygos vein, and thoracic duct. The esophageal hiatus, which is in the muscular portion, contains the esophagus and vagus nerves. This is the most common site of the hernias associated with the diaphragm. The

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EDITORIAL COMMENT: Within the past 6 months, a total of five traumatic ruptures of the diaphragm have been repaired at the University Hospitals.

vena cava along with some of the filaments of the phrenic nerve pass through the tendinous portion of the organ. The weakest portion of the diaphragm is laterally and posteriorly. Embryologically, this is the part which develops latest.

The majority of hernias usually occur on the left side; the right side is protected by the liver. Of course, the traumatic hernias which occur on a direct basis such as a penetrating wound due to a gunshot or a stab can occur on either side. The hernias due to a blunt trauma, most commonly associated with automobile steering wheel injuries, are of the indirect type and involve a sudden marked increase in intra-abdominal pressure. These hernias are not associated with the peritoneal covering. The only type of embryological diaphragmatic hernia which is not associated with a sac is the herniation through the space of Bochdalek. This is in the area of the pleural peritoneal sinus. The case presented today represents probably a combination of the traumatic rupture of a congenital weakness in the posterior portion of the diaphragm.

The symptoms associated with traumatic rupture of the diaphragm can be divided into three general phases. In the acute phase, the visceral contents in the chest may cause a shock state due to blood loss or venous obstruction secondary to the large mass. There is an associated mediastinal shift with a decrease in venous return to the heart. The diagnosis of this type of problem may be missed by the radiologist due to the usual presence of an associated pleural effusion. The presence of a pleural effusion has caused radiologists to misinterpret a diaphragmatic hernia as being a high diaphragm or an eventration. If the patient lives into the latent period, he usually presents with symptoms associated with partial obstruction and discomfort in the thorax. These complaints may involve vomiting, and pain in the shoulder, the lower thorax or the upper abdomen. All of these symptoms are usually intermittent. The pulmonary compression associated with a hernia of moderate size is not severe enough to cause significant dyspnea. Finally, in the late state, the patient presents with symptoms associated with incarceration, complete obstruction, and strangulation. He may also present as having a perforated viscus.

Several interesting reviews of this problem are available. In 1963 Lucido and Wall[1] reported 47 cases of traumatic rupture of the diaphragm. All but 4 of these were associated with automobile accidents. In their series they found that 43 of the cases involved the left side. There were only three traumatic ruptures of the right side, and one case involved both the right and left sides.

Another contrasting series is by Carter and Giuseffi[2] in 1948. This aggregate of 43 cases emphasizes the importance of abdominal exploration in the treatment of diaphragmatic hernia. This group was very different in etiology from the previous one presented as 38.2% involved stab wounds, 38.2% gunshot wounds, and 23.5% indirect trauma to the abdomen. All of those who did not have surgical exploration ultimately died, usually due to an injury to the spleen. Twenty-one of the 43 patients did have lacerated spleens. Several other organs were noted in this series to be repeatedly present in traumatic hernias. The transverse colon was present 53.4% of the time, the stomach 45%, the small intestine 25%, and the splenic flexure 23%. The spleen was present in the thorax in only 2 of these cases. From this review it is evident that the prognosis of the patient is directly dependent upon the organ which herniates and its injury, in addition to other associated injuries which may be lethal.

Dr. John Benfield: I feel the best approach to repair this type of hernia is transthoracically as was done in this case. The patient may have acute respiratory distress on the basis of a right to left shunt since a portion of lung may well be collapsed and unoxygenated blood is circulating through this area. This patient's initial symptoms were probably due to gastric dilatation which was readily relieved by a nasogastric tube. Of particular interest here is that the patient refused blood transfusions on religious tenets even if needed. However, no blood was required. Mr. Russell from the hospital administration is with us today. Perhaps he can give us some comments on the legal aspects.

Dr. Joseph Gale: This case shows that thoracic surgery can well be done without the use of blood. I feel that this patient probably had a small congenital hernia through which visceral contents were forced during her initial episode of trauma.

Dr. Robert C. Hickey: On calling for a vote regarding surgical approach, I see that 8 out of the 10 senior surgeons here would

Fig. 1—The admission chest roentgenagram demanstrating the gas-filled viscus in the left side of the chest.

Fig. 2—A barium contrast study confirming the presence of bowel in the chest.

prefer a thoracotomy. Doctor Gale, what is your feeling on this?

Doctor Gale: I agree that a thoracotomy is the best approach due to the presence of pleural adhesions and danger of complications by hemorrhage, if these adhesions were torn as the hernia was reduced through the abdomen.

Mr. John A. Russell: The conscious adult patient always has the right to refuse or accept treatment for any reason. This we are all agreed upon. However, in an emergency, the consciousness or unconsciousness of the patient must first be proved. Then a court order against the patient's wishes may be obtained if it is felt necessary that a transfusion is needed to save a life. At times a patient may be most uncooperative and the physician then has a right to refuse to treat the patient, to turn him over to another physician, or to send him home.

Doctor Hickey: If the patient did not ask regarding blood transfusion, and blood was given without the patient's expressed permission, is our position then unjustifiable? Does the consent for surgery include the possibility for transfusion?

Mr. Russell: I feel you must make it clear to the patient rather than assume that he knows all the possibilities.

Dr. William Young: Many groups are very firm on this point. Some will take it if needed, but they may not be adhering to the strict interpretation of their faith. Blood substitutes (dextran) are thought acceptable.

Mr. Russell: A court order can be obtained in the case of a child if the reason is sound in the opinion of the judge.

Doctor Hickey: As you can see the problem of trauma has led into a discussion of some of the medicolegal aspects of transfusion as well as the recognition and repair of the traumatic hernia. We are happy that this patient did well without the use of blood transfusion. The important aspect from this presentation is that of proper and successful management for the traumatic diaphragmatic hernia. We must plan now for another session on non-traumatic hernias through the diaphragm.

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Electrical Treatment of the Cardiac Arrhythmias

By GEORGE G. ROWE, M. D.
Madison, Wisconsin

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

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University of Wisconsin Medical School

■ ELECTRICAL CORRECTION of cardiac arrhythmias although old in principle has recently become popular because of the development of a capacitor type DC instrument and its popularization for use with the common arrhythmias.[1] The principle of electrical interruption of arrhythmias is simple, depending on the graded rhythmicity of the heart and that all electrical activity of the heart may be extinguished temporarily by an electrical discharge. Thus, it is expected that after depolarizing the entire heart the normal pacemaker, having the greatest rhythmicity, will assert itself and establish sinus rhythm.

The technique of this treatment has been widely described and will be reiterated only briefly in this report.[1, 2] It is generally recommended that this treatment be applied to subjects with chronic atrial fibrillation or flutter, ventricular tachycardia and ventricular fibrillation. Providing it is feasible the patient should receive at least 1.2 gm of quinidine daily in divided doses for one to two days prior to attempting electrical conversion. During this interval digitalis should be discontinued. In general, patients are anesthetized with short acting barbiturates for the actual application of the shock and it is thought desirable for 5% glucose to be administered intravenously so that the anesthetic and whatever medications are required, can be introduced easily when needed. The procedure may be done without anesthesia,[3] but in general, a narcotic is then required to allay apprehension and to reduce the discomfort of the electrical shock. Current machines are so designed that the electrical shock is delivered through the heart avoiding its "vulnerable period" and hence the risk of serious arrhythmia is reduced.[1, 2]

Although the technique of electrical conversion of cardiac rhythms is simple, and easily applied, the procedure should be discussed further to clarify expected results and complications which may arise. It is widely reported that 80 to 90 per cent of subjects with atrial fibrillation may be converted to sinus rhythm by this procedure.[1] It will be noted in referring to the older literature, that this is comparable to the conversion rate produced by administration of quinidine.[4]

The chief arguments given in favor of the electrical method are that it is simpler, safer, less time consuming, and less expensive. The latter may be debatable when it is considered that anesthesia is generally used and that the cost of the apparatus, its use, and maintenance, must be supported. It may be argued whether electrical conversion is more or less hazardous than quinidine administration. It will always be difficult to attribute death to a single cause in a subject who has heart disease which has precipitated an arrhythmia severe enough to require correction; nevertheless, several deaths appear to be attributable to each method of conversion. At least until the present time, more deaths have been reported with quinidine administration.[5] However, application of the electrical method to common arrhythmias on a large scale is relatively new and all of the results are not yet in. In general deaths have been presumed to be due to ventricular arrhythmias. Some have been attributed to

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digitalis intoxication on the thesis that digitalis is more toxic during sinus rhythm than during atrial fibrillation,[6] hence the recommendation that digitalis be discontinued for several days prior to electrical conversion of cardiac arrhythmias.[6,7]

Convincing reports of A–V block, frequent ventricular premature contractions, early and late ventricular fibrillation are available.[6] Furthermore, some subjects appear to have been converted from atrial fibrillation to an unstable state in which recurrent ventricular arrhythmias have occurred requiring repeated resuscitation over a period of hours. Three such subjects have been seen at the University Hospitals who have required resuscitation later on in the same day or the day after electrical defibrillation.

Embolism has always been a problem in subjects who have been treated effectively for atrial fibrillation.[4,5] It continues to be a problem in subjects treated by the electrical method, and there are reports of pulmonary and peripheral embolism subsequent to electrical correction of atrial fibrillation.[7] Hence, whenever one undertakes to defibrillate the atrium, he must also be prepared to treat embolism. Although electrical shock will damage the myocardium, it seems that the current devices which have been made for clinical use are safe in this respect and that the reported elevations in serum enzymes[8] were probably related to skeletal muscle damage from trauma to the thorax.

Relative contraindications to electrical conversion of cardiac arrhythmias are believed to exist in those who cannot take quinidine, since it is widely held that if subjects are not maintained on quinidine they will revert to the arrhythmia for which they were treated.[4] Digitalis intoxication constitutes a relative contraindication to electrical conversion, since it is believed to be more toxic in the presence of a sinus rhythm than it is during atrial fibrillation.[6] The history of recent embolus is thought by many to indicate that anticoagulants should be administered for three to four weeks prior to attempting atrial defibrillation. This period presumably prevents formation of fresh clots and insures that those already present will be sufficiently adherent that they will not be dislodged by the procedure or by effective atrial contraction.

Hemodynamic studies to date have not indicated as much improvement as one might expect subsequent to correction of atrial fibrillation.[9] Even though reports of clinical results have been encouraging, the failure to demonstrate marked hemodynamic improvement, the risks involved, and the propensity for arrhythmias to recur, suggest that further observations should be made concerning electrical correction of arrhythmias prior to its wide spread application. In view of the dangerous arrhythmias occurring during and after the procedure,[10] it is recommended that all patients who have had electrical conversion of the rhythm be observed for at least 24 hours after the procedure in a place where they may be treated if cardiac arrest or serious arrhythmia should occur.

1300 University Avenue (53706).

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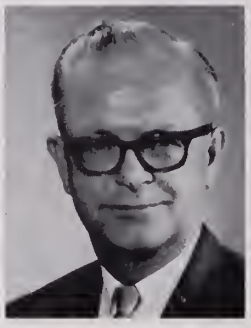
* * *

NEW FILM ON VARICOSE VEIN SURGERY

Corrective surgery for varicose veins and ulceration is described in detail for medical audiences in a new film made available through the Wyeth Film Library. The 16-mm, 22-minute sound film explains briefly the causes of varicose veins, illustrates diagnostic measures, demonstrates corrective surgical techniques, and shows postoperative results.

Suitable for showings to surgeons, surgical residents, interns, and students, the film is available on three weeks' notice through Wyeth representatives or through the Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

THE PRESIDENT'S PAGE . . .



J. H. HOUGHTON, M.D.
Wisconsin Dells

Conference on Health

■ IT WAS MY PRIVILEGE to attend the recent White House Conference on Health in Washington, D. C. on November 3 and 4. Space does not permit a full report, but I shall attempt to give you some of the suggestions made without going into detail:

"There is a developing partnership between Government and Medicine. This is a "Partnership for Progress," a public-private partnership and the Government must not dominate."

"Government wants to know how best to work with doctors, hospitals, etc."

"The Government is now involved for the first time in setting standards for the control of pollution of our physical environment."

"Medicare will be administered under the proven insurance mechanisms of Social Security."

"Medical care needs of tomorrow must shape the type of education provided today."

"Better utilization of existing medical manpower is imperative."

"We must become more flexible to changing environment."

"New medical centers will help in making new knowledge available on participating basis."

"In regional planning, there should best be a lay board of directors, perhaps assisted by doctors of Medicine."

"Only the young M.D. knows the new techniques. The rest are obsolete."

"Congress is to be commended for passing 12 significant health bills."

"This is only the foundation on which we will build."

"Consolidate gains already made and move ahead toward new goals."

"Government should provide resources for exercise and recreation and make them available to all."

"Consider concept of physician—assistant to free physician to employ those skills for which he is trained."

"There is a growing awareness that modern life demands a willingness to allow controls."

"More controls are inevitable."

"Population must be controlled by family planning but each family must have free choice in this."

The practicing physician and organized medicine had a very minor role in this Conference. The speakers were mostly educators, medical and others related to the health fields, Government people and a few representatives of Labor.

I purposely have not expressed any opinions relating to this Conference, although I have some very strong ones. I leave it to the reader to draw his own conclusions.

J. H. Houghton, M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Promotion of Samaritanism

■ OUR IMPULSES AS physicians to succor suffering humanity may, on occasion, collide with a prudent regard for our legal liabilities. Out of the tension arising from compassion and a fear of being made a party to a lawsuit alleging malpractice as a result of rendering free and voluntary assistance in an emergency has come the so-called good Samaritan legislation.

Fortunately, Wisconsin, 38 other states, and the District of Columbia, have all enacted laws protecting the physician from such lawsuits except in instances of gross negligence. The other 11 states, however, continue to expose the doctor to the avarice of the ungrateful victim and his unscrupulous lawyer who recognize an opportunity to take advantage of humane behavior.

To promote the passage of good Samaritan legislation throughout the country, a conference on the subject was recently held at the University of Chicago Law School. Entitled "The Good Samaritan and the Bad," the meeting was attended by legal authorities, philosophers, sociologists and newspaper representatives from the United States, Great Britain, France, and Australia. As citizens of Wisconsin, we can be proud of the fact that this conference was arranged and financed by Sentry Life Insurance Company of Stevens Point, a Wisconsin-domiciled organization that seems to be uniquely aware of the need for protecting rescuers from financial loss.

The consensus of those who attended the symposium emphasized the need for legislation not only to protect the doctors who would intervene to save life but also to compensate them for any loss they might suffer themselves. Some authorities would go further, as do those countries under the Continental legal system, by making a person who fails to render assistance liable to criminal prosecution. One of the most horrifying cases of recent record was that of Kitty Genovese in New York, whose attack and murder were witnessed by no less than 38 people, none of whom bothered to call the police, let alone intervene to save the victim's life. When public indifference to acts of violence against others becomes so thick, laws ought to be passed making such lack of action subject to penalty.

While good Samaritan legislation is a good beginning in the replacement of an abdicated moral responsibility with a legal obligation, additional laws should be enacted not only to protect the rescuer from the person he rescues but also to make sure that no potential rescuer can evade his duty. Our civilization is built on a basic concept of the sanctity of human life; our institutions are expressions of that concept, and our entire system of values is predicated on it. Any erosion of that concept must be challenged vigorously by governmental action as well as by private concern.

The Sentry Insurance Company is to be applauded for its initiative in sponsoring the symposium on "The Good Samaritan and the Bad," and it is to be hoped that the effect of the conference will produce legislation to reduce the hazard of life in an accelerated, crowded, violent world.

For those who are interested in the issue, a booklet summarizing the discussion of the conference may be obtained free of charge by writing Sentry Insurance, Stevens Point, Wisconsin. —D.N.G.

LETTERS

PHYSICIANS FOR AUTOMOTIVE SAFETY

To the EDITOR:

On April 7, at noon, 30 physicians of a newly organized Physicians for Automotive Safety made a "dignified protest" before the 1965 International Automobile Show at the New York Coliseum. Fourteen specific objections to current automobile design were indicated on the placards which the physicians carried. Since the protest, the response from the public and our fellow physicians reflects sentiment that our action was long overdue. Despite past intensive programs directed at control of the environment (the highway) and the host (man), little attention has been directed towards preventive countermeasures for the specific agent (the automobile). Defective automobile design is responsible for much of the epidemic injury, disfigurements, and disabilities.

All the previous resolutions of the American Medical Association and the American College of Surgeons asking that the industry make a safer car have been almost completely ignored. There will be no conflict with the regular medical organization activities on automotive safety and the Physicians for Automotive Safety will cooperate to reinforce the mutual objective.

The Physicians for Automotive Safety, as a smaller and more flexible organization, will direct programs specifically to effecting occupant protection in motor vehicles. Physicians for Automotive Safety represents an attempt at organization of the practicing medical profession to cope with a known mechanical epidemiologic agent. The nature of the present epidemic clearly justifies this approach.

Membership inquiries and suggestions for future action should be directed to Dr. Arnold Constad, Secretary–Treasurer, 527 Morris Avenue, Springfield, New Jersey. Basic membership fee is $5, contributing membership $15, sustaining membership $25 per year. Hopefully, physicians from every section of the country will join to give meaningful influence for this new medical group.

SEYMOUR CHARLES, M.D., *President*
Physicians for Automotive Safety
Newark, N.J.
and
LEO MAYER, M.D., *Vice-President*
New York, New York

TRANQUILIZERS IN ADDICTION

In all areas of medicine and within the past three decades, there has been a rapid development of new and potent drugs. These medications serve excellent therapeutic purposes and offer the modern physician the means for alleviating and even curing many of the ills that beset mankind. However, it has become more and more apparent that potent therapeutic agents carry with them the possibility and probability of serious and even dire side effects and complications.

The tranquilizing agents are no exception to this rule. The State Medical Society's Division on Nervous and Mental Diseases of the Commission on State Departments wishes to call the attention of the physicians of Wisconsin to the dangers in the use of ataractic agents. The usual precautions for the management of hematopoietic depression are necessary. Specific effects occur also, for example, precipitation of seizures by the phenothiazine group.

But addiction to these agents is of special concern to your division. These drugs must be considered as symptomatic therapy and not as alleviating the fundamental psychiatric disorder. Their constant use in major or prolonged psychiatric illnesses can induce an addiction as definitive as that brought about by the traditional narcotic agents. The possibility of inducing addiction becomes the responsibility of the individual physician.

SPECIAL TO THE JOURNAL

A Glance at Private Psychiatry in Wisconsin

By ALBERT A. LORENZ, M.D., WALTER R. CONNER, A.C.S.W., GORDON J. POLDER, Ph.D., and JAMES D. WATSON, A.C.S.W., Eau Claire, Wisconsin

■ THE DIVISION on Nervous and Mental Diseases of the Commission on State Departments of the State Medical Society of Wisconsin has entertained a continuing interest in learning more about the rapidly changing field of psychiatry in Wisconsin. The Division has found that most of the information available about the practice of psychiatry has come from government sources. Very little information on private psychiatry can be found.

Recently the role of the new "Dr. P.I.P.P." (Psychiatrist in Private Practice, named by Dr. James P. Cattell) has been emerging. The Biometrics Branch of the National Institute of Mental Health has been studying the private practice of psychiatry. This study shows that probably as many outpatients are seen by psychiatrists in private practice as by those practicing in clinics. Raymond Headlee, M.D., editor of the BADGER PSYCHIATRIC BULLETIN, editorialized in the January 1965 issue that "no mention of the cost of this to the patient was made, although we all know about what private psychiatrists charge . . . It is interesting to note that in Chicago at the recent Mental Health Congress it was reported that the cost per patient in one government clinic was $78.00 per hour. This, of course, did not include the cost of assessing tax, collecting it and redistributing it to this clinic, just clinic costs."

That same Congress heard reports that the psychiatrist's image is improving. However, one comment of a discussion leader was the most frequently heard remark which we must fight to correct and that is: "the average person cannot afford a psychiatrist."

The Division on Nervous and Mental Diseases also has become aware of the increased interest in mental health activities and is participating in the comprehensive mental health planning sponsored by the Wisconsin Department of Public Welfare. In order to help the Division disseminate current knowledge about private psychiatry and aid the comprehensive mental health planners, a committee was formed to study the private practice of psychiatry in Wisconsin.

METHOD. The authors started their work in November of 1964 by presenting a proposed questionnaire to committee members for their approval. As a result of their criticisms and recommendations, a questionnaire was developed and mailed to the roster of members of the Wisconsin Psychiatric Association as of Jan. 1, 1964. Unsuccessful attempts were made to obtain a list of psychiatrists engaged in private practice so the entire roster was used. One hundred and sixty-two (162) names appeared on this roster. Each member received an introductory letter which requested the receiver to disregard the study if he were not engaged in the private practice of psychiatry. The questionnaires were mailed on Jan. 18, 1965.

While the questionnaires were in the mail, facts were gathered in an attempt to gain some insight into a cost comparison between public and private care. All of the participants realized before the start of the study that attempting to study such a complex problem, full of innumerable variables, was a laborious task. If one were to wait, however, until a task had no risks, then few facts would be gained. The authors fully realize that their generalizations are limited, but they also feel that a sincere effort has been made to obtain "a glance at private psychiatry in Wisconsin."

RETURNS. Of the 162 questionnaires mailed, 42 were returned either completed or partially completed. This represents a return of 25.9% of the *gross* sampling. A few were returned unclaimed and a few were returned marked only that they were not in private practice.

OFFICE VISITS. Forty-one (41) psychiatrists (25.3% of the *net* sampling) answered that they collectively saw 1,206 patients during the week of January 24 to 30. These doctors saw an average of 29.41 patients during this week. The median number of patients seen was 30, while the range was from 10 to 54.

An attempt was also made to determine how often the reporting psychiatrists saw their patients. They were asked to report the number of patients seen: (1) more than once per week, (2) once a week, (3) one time per two weeks, and (4) about once a

Prepared for the Division on Nervous and Mental Diseases of the Commission on State Departments of the State Medical Society of Wisconsin following a study which was supported in part by a grant from the Charitable, Educational and Scientific Foundation of the State Medical Society at the request of the Council. The Division accepted the report at its meeting on April 25, 1965, and requested that it be published in the WISCONSIN MEDICAL JOURNAL.

month. The highest number of patients were reported to be seen once a week. The second highest, once a month.

HOSPITAL INPATIENTS. The question concerning the total number of hospital inpatients cared for during the week of January 24 to 30 was answered by 26 physicians. The average obtained from the returned questionnaire showed that they were responsible for 9.65 hospitalized patients during that week. The range ran from one to 31 patients. Twenty-two (22) psychiatrists reported that they saw their patients daily. The length of hospital stay per patient ranged from 6.5 to 30 days. The median length of stay was 21 days. The cost to a patient for hospital stay, including hospital and doctor bills, ranged from $250.00 to $1,000.00.

HOSPITAL OUTPATIENTS. Only 18 of the 41 psychiatrists reported that they saw outpatients at a hospital during the reporting week. These 18 psychiatrists saw a total of 204 outpatients. The largest number of outpatients seen were in the once-a-month group.

HOSPITAL CONSULTATIONS. Twenty-four (24) of the 41 psychiatrists reported that they engaged in hospital consultations. During the reporting week used in this study, 80 consultations were completed. Most of the consultations were completed in an hour. The length of time required to complete a consultation varied from ½ hour to 3 hours.

DIAGNOSTIC CATEGORIES OF PATIENTS. Thirty-four (34) psychiatrists reported that 30% of their patients were psychotic and required an average of 30 visits per course of treatment. Thirty-seven (37) psychiatrists said that over 55% of their patients were psychoneurotic and required an average of 78.21 visits. The range of the number of visits required varied from 10 to 100 for psychotics and 14 to 400 for psychoneurotics.

COSTS. It was felt that it would be informative to obtain some statistics regarding the cost for patients who wished to obtain the services of a private psychiatrist. Thirty-nine (39) doctors reported their fees which ranged from $10.00 to $30.00 for an hour of the psychiatrist's time. The average charge was $21.97 per hour with a median charge of $20.00 per treatment hour. One group of 27 respondents reported an average charge of $14.65 for a visit to the hospital inpatient. (Median charge was $10.00). The range of the cost for inpatients varied from $5.00 per visit to $52.00 which, in some instances, included electroshock treatment. Nineteen (19) psychiatrists reported charges for hospital outpatients which ranged from $5.00 to $25.00. The mean charge was $11.98 and the median $9.00. No determination was made of the time spent by the psychiatrist with his hospital outpatients. Charges for hospital consultations also varied from $10.00 to $37.50, the average being $25.22. (The median was $25.00).

Eighteen (18) psychiatrists responded to the questionnaire item regarding the total cost of patient care. They reported figures from $150.00 to $5,000.00. The average for the responses was $1,024.17. The median was $542.50.

COMMUNITY SERVICE. All 42 responding psychiatrists indicated that they contributed some time during the reporting month to community service. The average number of hours for the month was 10.06 hours. (Median 10.00 hours). One psychiatrist reported that he contributed 50 hours of community work regarding mental health during the month of January.

ASSOCIATES. The psychiatrists were also asked to report the number of clinical psychologists and psychiatric social workers associated full time with them. Nine (9) reported that they associate with clinical psychologists and 10 work with full time social workers. Another ten (10) reported that they have other professional personnel associated with them but the professions were not specified.

CONSULTATIONS TO OTHER AGENCIES. Thirty-six (36) psychiatrists reported that they are consultants to other agencies. One psychiatrist reported that he is a consultant to seven other agencies. Only 4 reported that they were not consultants to any agency.

IMPRESSION OF PUBLIC FACILITIES. A final question was asked about the private psychiatrist's experience regarding care of patients in public facilities. The question was asked, "What has your experience been with the psychiatric care of patients who have been in public facilities, i.e., is the care adequate, on par with private care, realistic social planning, reasonable drug dosages, and the like?"

The answers to this question were difficult to analyze and generalize; however, an attempt was made to gain an impression. The answers were independently rated by the authors on a three point scale utilizing a positive, negative, or neutral position. Twenty-nine (29) psychiatrists responded to this particular question with 17 in the negative category, 8.6 in the neutral category, and 3.3 in the positive category. (Mean values of raters). For the three raters there was perfect agreement in 21 of the 29 responses. Utilizing the technique of intraclass correlation, the reliability of rating for a single rater is equal to .83 while the reliability for the three raters combined is equal to .93. Thus, the ratings are regarded as highly reliable. It appears that the majority of the responding psychiatrists feel that private care is more adequate than care received in public facilities within the limits of the question posed.

COST COMPARISON. A cost analysis of the two different types of psychiatric care—private and public—is a complex problem requiring specialists not available to the authors. The question of cost comparison is asked and should be of interest to every taxpayer. In order to stimulate thinking in this direction the following facts have been gathered so that the reader can draw his own conclusions. No attempt will be made to form conclusions. A discussion will follow with the authors' thinking.

According to a State Department of Public Welfare report, the state mental hospitals served 6,123 patients during 1963 at a cost to the taxpayer of $11,700,000. The 35 county hospitals served 17,818 patients during the same year at a cost of $11,700,000. The 21 guidance clinics throughout the State served 9,393 patients at a cost of $700,000. Adding these services together, 33,334[1] patients were served by these facilities at a cost of $24,300,000. Some of the patients in these figures are outpatients and thus make an average cost per patient meaningless.

The per diem cost in 1963-1964 at state mental hospitals was $13.81, or $418.90 per month, while at county hospitals it was $5.23, or $158.64 per month.[2] Both figures represent the total charge for care per patient, i.e., cost for hospital room, psychiatrist's time, paramedical services, medical treatments, activity therapy, and the like. In the community clinics for the year 1964, 10,953 persons were served during 3,767 professional staff hours. A division of the figures above suggests that the approximate cost per hour of professional time at the community clinics in 1964 was $9.34.[3]

The state hospitals admitted 3,903 patients in 1963 while the county hospitals admitted 1,299 in the same year. In 1963 the average daily population in the state hospitals was 2,170 and in the county hospitals, 11,916.[4]

DISCUSSION. While the information obtained in the course of this admittedly limited study does not offer an opportunity for any concrete conclusions, many rather restricted generalizations and ideas can be correlated.

The need for private psychiatry in Wisconsin becomes apparent even from the limited number of respondents to the questionnaire. These 41 physicians saw a total of 1,206 patients during the week sampled. This indicates a demand on the part of the patient population for this type of psychiatric facility. However, it does not indicate the reason for the particular demand. The demand for private psychiatry during this week may be a result of lack of other resources, or it may represent a demand for the quality of the service offered as perceived by the patient. While there are most surely other factors involved, these alone give reason to reflect on the fate of private practice of psychiatry in Wisconsin.

Another limited generalization which reflects itself in the responses to the survey questionnaire suggests that the patient receives more individual attention per consultant or course of treatment with the psychiatrist in private practice than with the psychiatrist in the public facility over an equal length of time. According to the responses in this survey, the private outpatients were most often seen once a week for a psychiatric treatment session. Further, private hospital inpatients are most often seen by the psychiatrist daily. While no conclusive data are available, it is generally assumed that this experience is not replicated in the state hospitals and especially not in the county hospitals.

The median hospital stay for a patient under private psychiatric care is 21 days, while the average stay for the psychiatric patient at a state hospital is 90 days. The greater amount of time necessary to care for patients in a state hospital compared to the time necessary in a private facility has social ramifications which should be obvious. The authors are not so naive as to believe that all patients can be treated with equal dispatch in a private psychiatric facility, but they do firmly believe that many patients stay longer in the state hospitals due to a lack of private facilities where they might be more expeditiously treated. The authors feel that there is a need for support of both types of facilities with the critical concern being the most therapeutic value, both social and medical, for the patient.

With private psychiatric facilities available in a community, the general practitioner, as well as the nonpsychiatric medical specialist, has an opportunity for immediate psychiatric consultation. The authors feel that this need is not met by state-hospital or county-hospital psychiatry. In addition to consultation with other members of the medical profession for diagnostic or treatment purposes, the private psychiatrist has an opportunity to communicate with his medical colleagues on a nonspecific basis but one which leads to a greater understanding of community psychiatry. This, it would seem to the authors, is of vital importance first of all to the patient and then to the physician in that he may make more accurate referral to the proper facility, whether it be public or private.

It is apparent that the psychiatrists who responded to this study are community minded and volunteer considerable professional time to community education and service. How much time the psychiatrists in the public institutions contribute to community service and education is not known.

As has been noted previously, a direct cost per patient comparison is not possible with the information available. This is true because the per diem cost per patient does not necessarily reflect the per diem cost to the taxpayer, since the loss of income during confinement in a state or county hospital is not incorporated in this figure nor is the cost of the state or county in supporting a patient's family, should this be necessary, during his confinement.

It is the authors' firm conviction that both public and private facilities are needed and that the primary consideration for the use of either of these facilities is the welfare of the individual patient. The authors are well aware that the recommendation for a psychiatric treatment program must stem from consideration of many factors other than cost alone or available resources alone.

A particularly fine summary was given by one of the responding psychiatrists in answer to the question: "What has your experience been with the psychiatric care of patients who have been in public facilities, i.e., is the care adequate, on par with private care, realistic social planning, reasonable drug dosages, etc.?" He stated, "Basically, then, neither

public psychiatry nor private psychiatry is superior to each other; either is only as good as the practitioners therein, and both are essential in the treatment of the broad spectrum of psychiatric illnesses. They should seek to complement each other, not duplicate each other."

While the authors realize no issues have been settled by this investigation, they sincerely hope that it will generate many more questions which can be investigated and which may ultimately lead to a sophisticated and realistically patient-oriented psychiatric treatment program for the citizens of Wisconsin.

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2. Mr. Len Meshak, Social Research Analyst for Mental Hygiene, Bureau of Research, Department of Public Welfare, Madison, Wis.
3. Summary of Public Welfare Proposals for 1965–1967, State Department of Public Welfare, Madison, Wis., pp. 9–13.
4. Summary of Public Welfare Proposals for 1965–1967, State Department of Public Welfare, Madison, Wis., p. 11.

CHARITABLE CONTRIBUTIONS—1965

■ IT IS UNIVERSALLY acknowledged that the free giving of one's skills or substance for the benefit of others is among the noblest of human acts. What is less well known is that the Congress of the United States has fostered and encouraged individual giving far beyond the Biblical tithing. This legislative policy covers gifts to certain types of organizations whether made during life or after death of the giver. State legislatures have expressed a like policy, but have done so much more limitedly.

Because this article is concerned with the types of gifts which are deductible for income tax purposes, and such gifts are those which are made to certain categories of organizations rather than to individuals, gifts to individuals will not be discussed. This article is primarily for the information of physicians; hence corporate giving is not discussed. Since gifts made by will are so completely individual in nature, they, too, are not discussed here.

Especially during post-war years the number of organizations which solicit and need contributions has grown at a geometric rate. Earlier these consisted principally of churches, degree granting educational institutions and nonprofit hospitals. Today the number of categories which the law blankets under the phrase "charitable and cultural organizations" has been enlarged to include libraries, community centers to promote such cultural facilities as a symphony, repertory theater, ballet or opera, and, of special interest to physicians, certain medical research organizations and museums of science, art or history.

Two Kinds of Physician Giving

A typical physician does two kinds of giving. One is the contribution of the value of all or part of his services to needy patients, whether in his private practice or in public health centers. Closely related are his teaching services in hospitals and medical schools in the case of those who do not make this a career.

A significant aspect of contribution of professional services by a physician is that they are not recognized under the law as a form of property because they have not been converted into cash or some other form capable of valuation. For that reason, no income tax deduction is allowable for contributed services. Such contributions, however, automatically reduce the physician's time for the production of taxable income and for that reason they reduce the gross income which the donating physician earns and must report for income tax purposes.

The second type is his contributions of money or other property to one or more organizations which fall within one of the categories established by federal income tax laws. Within limits set out later, contributions to such organizations are deductible on the personal income tax return of the giver.

The balance of this article will concern itself exclusively with the federal law.

Elements of a Valid Gift

For a gift to be valid, either as a matter of general or income tax law, four elements must be present. The first is that the giver must be legally competent. Second, he must intend to make the gift without receiving any promise or thing of equivalent value from the recipient. Third, the thing given must be a form of property recognized by the law and capable of valuation. Fourth, there must be delivery of the donated property either physically or symbolically.

Income Tax Recognition of Contributions

Deductions for contributions may be taken only in the year in which a gift is made. A promise, or even a formal pledge to make a gift, is not deductible because by definition neither is a completed gift.

While contributed services are not deductible for reasons earlier noted, out-of-pocket expenses incurred by the physician or other giver in the course of donating his services are deductible provided such donated services were rendered to a charitable organization, recognized as such by the Internal Revenue Code, or to a unit of government.

Gifts in the form of cash or checks create no valuation problems except that the giver should preserve a record of the gift sufficient to satisfy the tax authorities, particularly where cash is paid.

The value of contributions of listed stocks or other securities can be determined by a broker's office. This is preferable to reliance on the quotation contained in a newspaper since the latter is always open to possibility of typographical error.

The value of such types of property as unlisted securities, land, a building, a used car or a work of art may present difficult and even complicated questions of valuation. The same is true of a gift of part or all of the income from certain securities or certain improved property, whether such gift be for a specified term of years or permanently.

The valuation of such gifts must be determined before a deduction can be taken on the giver's personal income tax return. It is also needed to complete a Treasury form required when the value of a gift exceeds $200. The most sensible procedure is for the giver to obtain a valuation of the donated property from a recognized and disinterested person or organization which has acknowledged expertness in the type of property which was given.

Future and Partial Gifts

The Internal Revenue Code permits the deductibility of gifts to take effect at some future time in the case of two types of property. One is real estate and the second is *intangible* personal property such as a lease or a patent. Thus, if a physician gave his home to a charitable foundation, but reserved to himself and his wife the right to remain in the home for the balance of their lives, such a gift is deductible in the year in which it is made. It is measured by the fair market value of the property on the date of the gift, reduced by the dollar value of the right of occupancy reserved by the physician for himself and wife. Such value is measured by the life expectancies of the physician and his wife.

In much the same way, deductible gifts can be made of leases, securities and patents which reserve in the giver, and one or more persons designated by him, the right to income for a specified term of years or for life.

An amendment to the Internal Revenue Code effective July 1, 1964, allows no income tax deduction for charitable gifts of *tangible* personal property so long as the actual possession and enjoyment of such property remains in the giver or persons closely related to him.

As an example, if a physician gave a valuable painting to an educational foundation under a stipulation that it was to remain in his home the balance of his life, he could take no income tax deduction for the gift until he gave up the actual possession of the painting to the foundation or to an individual from whom he can't get it back. Property of this kind is not considered donated until it gets outside the possession and control of the giver or his "tax relatives."

In the absence of court decisions, the best current opinion is that the 1964 amendments continue to grant recognition to partial gifts of real estate and of both tangible and intangible personal property, the three categories discussed above. For example, a physician might give a one-fourth interest in his residence over each of four years. It appears that he could do so even with a work of art and take a deduction so long as he let such work of art out of his possession for that fraction of each year equal to the donated fraction of his title to the property. Thus if he gave a one-fourth interest in a painting to a foundation in the year 1965 he would have to provide that the painting be outside his control and that of his immediate family for at least three months of the year before he could claim an income tax deduction.

Ceilings on Giving

With two exceptions later noted, the deduction ceiling for gifts to organizations recognized by the Internal Revenue Code as entitled to be the recipients of the kinds of gifts which are deductible on the return of the giver may not exceed 20% of the "adjusted gross income" of such giver. The term "adjusted gross income" means gross reportable income reduced by those expenses attributable to the production of such income.

The first exception permits an additional deduction of 10%, which means a maximum of 30% of the adjusted gross income. The following organizations qualify for the excess between 20% and 30% of adjusted gross income in the case of the individual giver: churches, schools, certain organizations holding property for schools, nonprofit hospitals, certain medical research organizations; federal, state or local governmental units where the gift is made exclusively for public purposes; and charities or cultural organizations which normally receive a substantial part of their income from a governmental body, the general public, or both. Examples of the latter categories are the American Red Cross, the United Givers Fund, publicly or governmentally supported museums, symphonies and the like. Gifts to private charitable foundations generally do not qualify for the additional 10% deduction but do qualify under the first 20% where they have received income tax exemption from the federal government.

The second exception is the so-called "unlimited charitable deduction." Very few taxpayers qualify for this since the combination of their deductible contributions and income taxes must have exceeded 90% of taxable income, specially computed, in eight of the ten preceding years.

The 1964 amendments to the Internal Revenue Code also contain a five-year carryover provision which can be valuable where a giver exceeds his maximum in a particular year. This provision is limited, however, to the types of gifts recognizable for the excess of contributions over 20% and under 30% of his adjusted gross income. The provision

does not apply to gifts which do not fall into such category, such as those to a private foundation without governmental or general public support.

Tax Savings From Giving

Broadly speaking, a person who makes a contribution which the law permits him to deduct derives two tax advantages from doing so. The first is the reduction in his income tax, and the second is a reduction in his estate tax liability. Where the property given has not increased in value over the giver's income tax cost, the gift will permit an income tax saving at whatever his federal rate is for the year in which the gift is made. Further, the property so contributed will correspondingly reduce his estate, and the saving there will be measured by the top estate tax rate or rates applicable to the valuation represented by the gift.

Thus, a gift of $10,000 cash for a taxpayer whose rate in a particular year is 55% can be made at a net cost of 45%, or $4500. If the giver were to die within several years after making the gift, the $10,000 given would represent a reduction in the assets he would otherwise have left. If his federal estate tax rate was 30% this would represent a further saving of $3,000. Thus the combination of income tax and estate tax savings, disregarding certain refinements in computation, would be $8500. This means that on the assumed facts he made a gift of $10,000 at a net cost to himself of $1500.

Special considerations are presented where the gift is one of securities or land which have appreciated in value. Such gifts are credited at the appreciated value. There the saving to the giver is represented by his not having to pay a capital gains tax of as much as 25% on the appreciated value. In addition, the value of the property comes off the top of his estate and thus represents maximum estate tax savings.

It is also possible for a giver to obtain an income tax contribution for the appreciated portion of the donated property completely severed from that part which represents his cost. Thus, he can sell the property to an organization at his cost and make a gift of the appreciated portion.

For example, a physician might own real estate immediately adjoining a nonprofit hospital. The hospital might wish this land and the physician might wish to make a gift of the appreciated portion of its value. Assuming that the land cost him $9,000, and that it now has a fair market value of $25,000, he could *sell* the land to the hospital for $9,000 and could *donate* and take a gift deduction for the balance of $16,000 represented by appreciation in value. Such a practice is increasingly common.

An article such as this inevitably oversimplifies and does not begin to present the difficulties either of valuation or of tax computation, or the determination of what organizations are eligible for various deduction limits. A physician who embarks on a program of substantial giving, particularly where it may involve more than one year, or may be part of his estate planning, will be well advised to do such planning only with the assistance of an attorney and a certified public accountant who are experienced in these fields. Legal and tax considerations make it foolhardy for the physician to proceed without expert advice in these areas of the law and of taxation.

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens. The Foundation administers these gifts in accordance with the stated desires of the donor and such gifts are deductible for tax purposes.

Among the many projects which are supported by this method is the medical student loan fund which has been given recent impetus by the donation of various surplus "Sabin on Sunday" funds from around the State and by significant donations from individuals.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

Research activity such as the Menominee County Health Survey which was presented to the fall 1964 interim session of the House of Delegates of the State Medical Society, the microscope loans, collection of medical stamps, and erecting appropriate historical markers denoting physician contributions to the history and welfare all go to make up the vast array of programs and services known as the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

SUMMARY REPORT

1965 INTERIM SESSION

HOUSE OF DELEGATES

Madison, October 9, 1965

The Interim Session of the House of Delegates was held Oct. 9, 1965, in Madison with the House considering six resolutions and reports of the Council, Officers, Divisions, Committees, and Commissions of the Society.

Reports on Special AMA Meeting Regarding P. L. 89–97, "Medicare"

The President and the American Medical Association delegates presented reports at the morning session on the special meeting of the AMA House held in Chicago Oct. 2 and 3, 1965. The purpose of the AMA meeting was to consider pertinent Federal legislation dealing with health care.

Dr. J. H. Houghton, Wisconsin Dells, president of the Society, spoke on the general actions and policies which have been adopted by the AMA since the enactment of "Medicare" and stated that the AMA has consulted with the Department of Health, Education and Welfare (HEW) regarding administrative rules for the new program.

He stated that consultation with HEW on the implementation of P.L. 89–97 was the only way possible to safeguard, to some extent, the best medical care for recipients.

Drs. A. L. Bernhart, Milwaukee, and John M. Bell, Marinette, AMA delegates, reviewed policies reaffirmed at the Chicago meeting and stated that, in summary, the AMA House approved the principle that a physician acting independently must make his own decisions as to the degree of his participation in the program.

Dr. E. J. Nordby, Madison, vice-chairman of the Council, presented the supplementary report of the Council. This report included several resolutions (see action on resolutions listed below), which were forwarded to the House for consideration.

The House had received the recommended 1966 budget from the Finance Committee of the Council. The budget, with accompanying material, was essentially the same as the one submitted in 1965. No increase in dues was recommended. The House was asked to recognize that 1966 may bring unanticipated developments, which could require postponement of some normal Society routines and activities. Doctor Nordby also recorded the Council's agreement with the recommendation of the Finance Committee as reported directly to the House. Dues will remain at $100.00.

Resolutions

Resolution A . . . recommended support of the invitation for a national rural health conference in Milwaukee. ADOPTED

Resolution B . . . urged the establishment of a separate cabinet post designated as Secretary of Health. The resolution was submitted because of the large role that government health programs now play in the lives of all Americans and because it was felt that a properly qualified Doctor of Medicine should direct a cabinet post administering these programs. ADOPTED

Resolution C . . . proposed a means to assure respect on the part of government employees administering "Medicare" for the confidential nature of the physician–patient relationship and medical records. The resolution as adopted reads as follows:

> "*Resolved,* That the State Medical Society of Wisconsin be on record that appropriate steps should be taken by the government of these United States to promulgate special ethical standards of conduct for government employees which will protect the patient, assure that the physician-patient relationship is not destroyed and that the confidentiality of medical records is guaranteed; and be it further
>
> "*Resolved,* That this resolution be transmitted to the Wisconsin Congressional delegation and others of prominent influence." ADOPTED

Resolution D . . . related to "Medicare" and was adopted in the following form:

> "*Resolved,* That the State Medical Society of Wisconsin ask that all of its component medical societies take immediate steps to create, where necessary, and to implement in all cases, appropriate programs of utilization review to serve all hospitals and extended care facilities in their respective jurisdictions to the extent that such hospitals and extended care facilities do not have their own duly established programs; and be it further
>
> "*Resolved,* That the State Medical Society endorses the full statement of the House of Delegates of the American Medical Association 'that hospital utilization review committees shall be composed of practicing physicians;' and be it further
>
> "*Resolved,* That the State Medical Society pledges its assistance to component societies in fulfilling the requirements of the law and its implementation in public interest; and be it further
>
> "*Resolved,* That the State Medical Society disseminate information and recommendations on legal responsibilities and other problems as they become available from the Advisory Committee on Hospital Utilization Review Committees of the Commission on Medical Care Plans; and be it finally
>
> "*Resolved,* That at the discretion of the Council, copies of this resolution be provided all interested parties, including hospital organizations, national organizations, governmental agencies, and other associations of professions." ADOPTED

Resolution E . . . endorsed the efforts of the American Medical Association in its publicity cam-

paign aimed at the eradication of venereal disease and pledged active support of the Society to the Wisconsin State Board of Health in its program of public education and reporting of this disease.

ADOPTED

Resolution F . . . placed the State Medical Society on record as endorsing the observance of Community Health Week, which is being sponsored by the American Medical Association (November 7–13) and encouraged active participation of component societies in their respective communities.

ADOPTED

Actions

On the basis of reports from the Council, Divisions, Committees, and Commissions of the Society, the House:

1. Endorsed the recommendation of the Commission on State Departments that it study the proposal by a legislative committee to discontinue the Diagnostic Center in Madison.
2. Accepted the report of the Commission on Medical Care Plans and commended the Commission and management for the work that has been done. Special note was taken of the fact that operating expenses are within the 10% goal of the estimated budget.
3. Urged that the Society, as proposed in the report of the President, continue to work with Student AMA groups and to develop further liaison between the State Medical Society and medical schools.
4. Noted the interim appointment by the Council of W. J. Egan, M.D., as Councilor from the 12th District to fill a vacancy until next May.
5. Declared or reaffirmed legislative position on:
   a. Reaffirmed opposition to pending "PKU" legislation which would require testing to be done on a compulsory basis and adopted the position that attempts be made to assure that when tests are performed, that they can be performed by any qualified laboratory in the State.
   b. Reaffirmed support to the principle of requiring reporting of cases of suspected child abuse providing immunity is guaranteed for the reporting physician.
   c. Concurred in opposition to Bill 368, A., which is designed to restrict the physician in his proper use of the dispensing optician.
   d. Recommended that all State Senators be once again advised of the inherent dangers to public health that are present in proposed legislation which would allow the chiropractor to use the title "Doctor."
6. Accepted the recommendation of the Supplementary Report of the Commission on Public Policy that the feasibility of conducting a conference on Wisconsin Health Fads and Fallacies in Milwaukee with the assistance and cooperation of The Medical Society of Milwaukee County be investigated.
7. Recommended that there be increased activity under the direction of the Commission on Public Relations and Communications to further encourage requests from the general public for physician speakers, films, pamphlets, and exhibits on the problems presented by health fads.
8. Accepted the report of the Commission on Public Relations and Communications and commended H. Kent Tenney, Jr., M.D., for his direction of the *March of Medicine* and for the personal attention he has given to listeners of this program.
9. Adopted the report of the Committee on Occupational Health and accepted its recommendation that occupational health clinics be reactivated, under the auspices of the CES Foundation, with the first scheduled for Milwaukee in November of 1966.
10. Concurred in acceptance of the Report of the Division on Rehabilitation as submitted to the House and previously circulated.
11. Considered the reports of the Wisconsin delegation and the staff concerning the special session of the House of Delegates of the American Medical Association and expressed confidence in the Wisconsin delegation and added further endorsement to the program of the AMA and the AMA Board of Trustees.
12. Accepted the Report of the President and expressed complete accord with the attitude that the Society should encourage further cooperation and strive for continued improvement in the plan.
13. Accepted the report of the Secretary and endorsed the principle of a State administrative body which can serve the public health by evaluating proposals relating to such matters as compulsory testing programs, where the expert fields of research and the practice of medicine can be combined through representation of the two medical schools, the State Board of Health, the State Board of Medical Examiners, and the State Medical Society.
14. The House reviewed the informational report of the CES Foundation and commended the activities of the Foundation, particularly in the area of loans to medical students. The House stated the belief that additional funds must be forthcoming if the Foundation is to continue effective activities in scientific teaching, public health education, and student loans.

    Because the House felt that further strengthening of the administrative structure of the Foundation required additional funds, it adopted the recommendation that the following statement be inserted in annual billings for Society dues:

    "A voluntary contribution of $10.00 to the CES Foundation was recommended by the House of Delegates in October, 1965."

the wisconsin medical journal

IND

HOUSE of DELEGATES

REPORTS AND PROCEEDINGS OF 1965 INTERIM SESSION

SEE SUPPLEMENT

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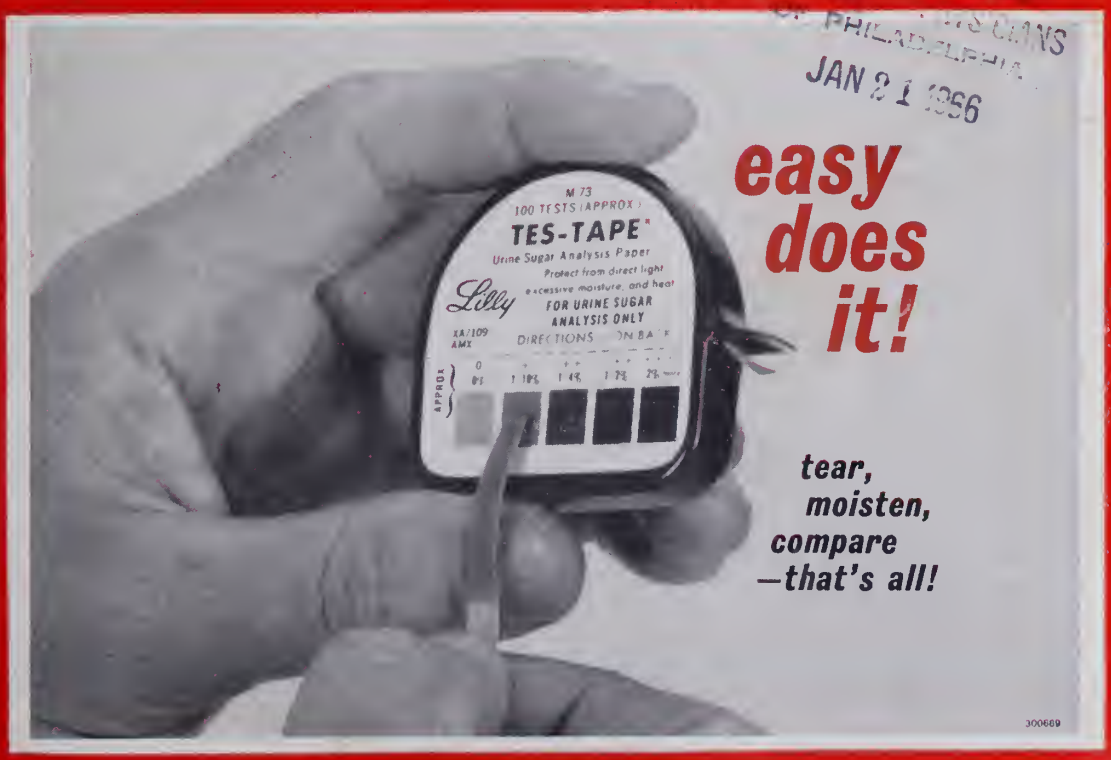

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COUNTY SOCIETY PROCEEDINGS

BROWN

New members of the Brown County Medical Society are Drs. *Edward J. Laskowski, Donald J. Gallagher,* and *Oliver Rian,* all of Green Bay. Doctor Rian is a transfer from Peoria County Medical Society, Peoria, Ill.

Society members met October 14 to hear a talk on congenital heart disease by *Dr. Thomas Meyer,* assistant dean of the University of Wisconsin Medical School.

DANE

Dr. C. K. Kincaid was elected president-elect of the Dane County Medical Society at its annual meeting October 12 in Madison. Other new officers are *Dr. Gordon Davenport,* vice-president; *Dr. John Morledge,* secretary-treasurer; *Drs. W. T. Russell, H. M. Suckle, G. J. Derus,* and *G. E. Oosterhous,* delegates; and *Drs. E. I. Boldon, J. F. McIntosh, E. E. Johnson,* and *L. G. Crocker,* alternates.

New members of the society are *Drs. Robert B. Andrew, James M. Huffer, Jack C. Westman, Martin Plotkin, Geoffrey M. Brittin, George H. Handy, Richard B. Arnesen,* and *Edward S. Orman.*

Doctor Andrew is in private practice at the Dean Clinic in Madison. A native of Detroit, he received his medical degree from the University of Michigan. After interning at the U.S. Naval Hospital in Chelsea, Mass., he served his residency in ophthalmology at Wayne State University Hospital.

A native of Madison, Doctor Huffer is an instructor in orthopedic surgery at the University of Wisconsin Medical School. He received his medical degree from the University of Chicago, and served his internship and residency at Strong Memorial Hospital in Rochester, N.Y.

Doctor Westman was born in Michigan and obtained his medical degree at the University there. He interned at Duke Hospital in Durham, N.C. After completing a six year residency in psychiatry, he was associated with the Children's Psychiatric Hospital and University of Michigan Medical School in Ann Arbor. He is presently head of the Child Psychiatry Division and a professor in the Department of Psychiatry at the University of Wisconsin Medical School.

Doctor Plotkin was born in Brooklyn, N.Y., and obtained his medical education at the Chicago Medical School. He served his internship at Michael Reese Hospital in Chicago and is presently a resident in orthopedic surgery at University hospitals.

Doctor Brittin is associate pathologist at Madison General Hospital and on the teaching staff of the University of Wisconsin Medical School. He received his medical degree from Columbia University College of Physicians and Surgeons. After interning at Johns Hopkins Hospital, he completed five years of residency work in pathology at the National Institutes of Health, Bethesda, and at the University of Minnesota.

Physicians whose names appear in italics are members of the State Medical Society.

Doctor Handy transferred to the DCMS from Marshfield and the Wood County Medical Society. He is a native of Idaho and graduated from Rush Medical College in Chicago. He served his internship in the King County Hospital System, Seattle, and completed his residency in public health at Presbyterian Hospital, University of Minnesota. Doctor Handy is presently a physician in preventive medicine at the State Board of Health.

Doctor Arneson received his medical degree at Western Reserve University and served an internship in pediatrics at Cleveland Metropolitan General Hospital. He is presently a resident in psychiatry at University Hospitals.

Doctor Orman, a native of Milwaukee, graduated from the University of Wisconsin Medical School. After serving an internship at Mt. Sinai Hospital in Milwaukee, he completed his residency in psychiatry at University Hospitals, and is now taking additional postgraduate work there as a resident in child psychiatry.

Dr. Ovid O. Meyer, professor of medicine at the University of Wisconsin Medical School, presented the scientific program at the November 9 meeting held at the University Medical Center. His subject was "Present Day Treatment of Leukemia and Lymphomas."

DODGE

The Dodge County Medical Society prepared a series of articles for Dodge County newspapers as a public service during the third annual observance of Community Health Week, November 7–13. The articles were aimed at promoting greater understanding of specific health problems and needs.

Drs. George E. Burgermeister and *Paul R. Glunz,* both of Beaver Dam, are new members of the society.

At their October 28 meeting, Dodge County Medical Society members heard Dr. E. R. Levine, assistant professor of medicine at the University of Chicago Medical School, speak on "Some Aspects of Inhalation Therapy."

DOUGLAS

Dr. Victor E. Ekblad, Superior, was elected 1966 president of the Douglas County Medical Society at its November 3 meeting in Superior. Other officers for 1966 are *Dr. Enzo Krahl,* Superior, president-elect; and *Dr. Robert L. Sellers,* Superior, secretary-treasurer.

At this meeting the members heard Dr. Warner V. Slack, instructor at the University of Wisconsin Medical School, speak on "Applications of Digital Computer Techniques in Clinical Medicine." At the October 6 meeting, *Dr. Samuel R. McCreadie*, assistant professor at Marquette University School of Medicine, spoke on "Cancer in Children."

Dr. Richard H. Stone, Superior, is a new member of the society.

FOND DU LAC

Edwin J. Holman of Chicago, legal counsel for the American Medical Association, addressed a joint dinner meeting of the Fond du Lac County Medical Society and Fond du Lac County Bar Association October 28 at the Elks Club.

Holman discussed "Recent Landmark Decisions of Interest to Medicine and Law." A panel discussion on the theme was conducted with *Dr. D. W. McCormick* and *Dr. J. S. Heubner* representing the physicians.

Dr. Howard Mauthe introduced the guest speaker. *Dr. Robert Schroeder* was program chairman. About 75 physicians and lawyers attended the session.

MARINETTE–FLORENCE

A joint meeting of the Marinette–Florence County Medical Society and the Menominee County Medical Society (Michigan) was held October 20 to discuss the effectiveness of their polio programs. There have been no polio cases in either county since the initiation of the polio vaccine injection 10 years ago. *Dr. James Boren*, Marinette, and Dr. John Heidenreich, Daggett, presidents of the two societies, presided.

FILMS—REDUCING FETAL MORTALITY

Two new motion pictures to aid physicians and hospitals in reducing fetal mortality in Rh-negative sensitized pregnancies have been released to the medical profession by Abbott Laboratories. The films describe in detail two relatively new procedures that can reduce fetal deaths in the sensitized pregnancy from 25 per cent to perhaps 5 per cent or less.

One of the films covers the diagnostic technique of amniocentesis and spectrophotometric analysis of the amniotic fluid which, when employed with standard parameters, permits a very precise diagnosis of the extent of fetal involvement and the determination of the optimum time for delivery. The other motion picture discusses the latest refinements of intrauterine fetal transfusion which has improved the prognosis for babies who otherwise would die before 32 weeks gestation, too early for survival if labor were induced.

Both films are available on free loan to professional groups from Abbott Laboratories, Film Service Department, North Chicago, Illinois 60064.

On October 21 the physicians heard a program on physical treatment of the hemiplegic by Dr. George H. Koepke, associate professor at the University of Michigan Medical School, and differential diagnosis of hemiplegia by Dr. Earl R. Feringa, chief of neurology services at the Ann Arbor VA hospital.

NINTH COUNCILOR DISTRICT

The Ninth Councilor District held its fall meeting November 11 in Marshfield.

During the afternoon session, papers were presented by *Dr. Joseph M. Freeman, Jr.*, Wausau, "Practical Exercise Tolerance Tests for Electrocardiograms;" *Dr. Dean A. Emanuel*, Marshfield, "X-ray Visualization of the Coronary Arteries of the Heart;" and *Dr. H. A. Anderson*, Stevens Point, "Present Sanatorium Treatment and Prophylactic Therapy of Tuberculosis."

For the evening session, officials from the State Medical Society and Wisconsin Physicians Service discussed the current aspects of preparing the ground work for Medicare from the viewpoint of the Social Security department and the private insurance company.

Dr. M. V. Overman, Neillsville, is president of the 9th Councilor District Medical Society, which was formed in 1879 to further postgraduate medical education. It has met one to four times yearly since and includes 13 central Wisconsin counties.

PRICE–TAYLOR

Dr. Mahmood Mirhoseini, Medford, was elected president of the Price–Taylor County Medical Society at its October 16 meeting in Medford. Other new officers are *Dr. W. E. Niebauer* of Phillips, vice-president; and *Dr. W. W. Meyer* of Medford, secretary.

Doctor Mirhoseini spoke to the members on "Occlusive Arterial Disease of the Lower Extremity."

SAUK

Sauk County Medical Society has awarded $400 annual nursing scholarships to 15 nursing students in the Sauk County area this year. Funds for these scholarships were obtained from the accumulation of immunization programs over the years.

WAUKESHA

The Waukesha County Medical Society and Auxiliary met in October at the Waukesha County Hospital to hear *Dr. Chester Wade*, Delafield, speak on the hospital and the facilities now available for county residents.

WINNEBAGO

Winnebago County Medical Society members and their wives attended a cocktail party and dinner November 14 in Neenah. *Dr. Ralph Suechting*, Neenah, spoke on "A Tour of Russia."

Fond du Lac Unit WHA, Winnebagoland Nurses

The Fond du Lac County Heart Division of the Wisconsin Heart Association and the Winnebagoland District Nurses Association sponsored a nursing seminar on five consecutive Tuesdays, October 26–November 23, in Fond du Lac.

The seminar, entitled "The Cardiac and the RN," was addressed by eight specialists in various areas of cardiac nursing. The physicians who spoke were *Dr. Armin Baier*, internist, Milwaukee; *Dr. Derward Lepley, Jr.*, associate professor of surgery, Marquette University School of Medicine; and *Dr. Hugh J. McLane*, internist, Fond du Lac.

Wisconsin Chapter, NAF

The Wisconsin chapter of the National Arthritis Foundation held its annual luncheon meeting November 2 in Milwaukee. The speaker was Dr. John H. Vaughan, Rochester, N.Y., chairman of the medical advisory and scientific committee of the Foundation.

Wisconsin Division, ACS

Dr. Gail H. Williams, Marshfield, was elected president of the Wisconsin Division of the American Cancer Society at its annual meeting October 14 in Madison. Doctor Williams succeeds *Dr. Glenn Smiley*, Delavan, who served in that position for the past two years.

Doctor Williams is a member of the Marshfield Clinic staff and is on the attending staff of St. Joseph's Hospital, Marshfield. He has been active in the cancer-control program of the American Cancer Society and at the time of his election to Division president, was chairman of the Division's Service Committee.

A 1949 graduate of the University of Michigan Medical School, he served his internship and surgical residency at the Medical Center there. Following this, he was senior clinical instructor and instructor in anatomy at the school.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Doctor Williams is a member of the Wood County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Frederick A. Coller Surgical Society, and is a Fellow in the Society of American College Surgeons. In 1958 he was a Diplomat, American Board of Surgeons.

In addition to Doctor Williams' election, other activities at the annual meeting were: training sessions for volunteers, reports of cancer research, and a talk by *Dr. Robert J. Samp*, University Hospitals in Madison, on "Medical School and American Cancer Society: Post-Graduate Programs."

Wisconsin Association of Blood Banks

The Wisconsin Association of Blood Banks held its interim meeting October 2 at St. Joseph's Hospital, Marshfield. *Byron A. Myhre, M.D.*, Ph.D., Director of Blood Bank at Milwaukee County General Hospital and president of the Wisconsin Association of Blood Banks, said the program was well received by 25 participants.

AAMA Convention

The ninth annual convention of the American Association of Medical Assistants was held October 10–17 in New York City. The Wisconsin unit of the society was represented by Miss Alice Bundy, Milwaukee, a past president of AAMA; *Dr. Daniel Dorchester*, Sturgeon Bay, advisor; and Mrs. June Gillette, a Board of Trustees member. The four delegates to the House of Delegates were Miss Alice Roelse, Port Washington, WSMAS President, Miss Edith Murphy, Milwaukee, Mrs. Peggy Gallagher, Waukesha, and Mrs. Vera Erdman, Appleton.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Mielke at Appleton

Dr. John E. Mielke, internist with a sub specialty in cardiovascular and renal disease, has returned to Appleton to practice medicine with his father, *Dr. E. F. Mielke.*

A graduate of the University of Wisconsin Medical School, Dr. John Mielke interned at University of Minnesota hospitals. He studied at the Mayo Clinic and was awarded a Masters of Science degree in internal medicine by the University of Minnesota.

Dr. Wood Closes Amherst Office

Dr. C. F. Wood, Iola physician who had been holding office hours four afternoons a week in Amherst, has discontinued his Amherst practice.

Awards to Gundersen, Marshfield Clinics

The Gundersen Clinic, La Crosse, and the Marshfield Clinic, Marshfield, were awarded plaques recently for their participation in a study of "Farmer's Lung", a pulmonary disorder produced hy inhalation of "dust" from moldy hay, grain or silage.

Drs. Eckstam, Scott Speak

Dr. Eugene Eckstam, Monroe Clinic, presented a talk on smoking following the showing of a newly released film on smoking, "Who, Me?", October 28 at a meeting of the Green County Unit of the American Cancer Society.

Dr. John Scott, Madison nose and throat specialist and assistant professor of clinical surgery at the University of Wisconsin Medical School, gave a talk on smoking following the showing of the same film November 2 at a meeting of the Dane County Unit of the American Cancer Society.

Five Doctors Address Nursing Seminar

Five Wisconsin physicians spoke at a three part nursing seminar on cardiovascular disease, sponsored by the Marathon County Unit of the Wisconsin Heart Association and the Mid-State District Nurses Association.

Speakers for the sessions held in October and November were: *Dr. Thomas C. Meyer*, assistant dean of the University of Wisconsin Medical School; *Dr. William P. Young*, University Hospitals, Madison; *Dr. D. J. Freeman*, Wausau internist; *Dr. James L. Struthers* and *Dr. James D. Kramer*, both Wausau physicians.

Dr. Cherry Heads Meeting

Dr. James Cherry, assistant professor of pediatrics at the University of Wisconsin Medical School, presided over the semi-annual meeting of the Madison Association for Education of the Deaf on October 25. The group, of which Doctor Cherry is president, was formed by parents of deaf children and teachers to exchange information on language, speech, and emotional development.

New Clinic at Milwaukee Hospital

A weekly clinic devoted to instructing women in the rhythm method of family planning opened November 3 at County General Hospital, Milwaukee. *Dr. Richard Mattingly*, chief of gynecology and obstetrics, said the clinic was the result of increased requests for family planning of all kinds.

Dr. Allen on Committees, Paper Published

Dr. John Allen, medical director of the State Department of Public Welfare in Madison, has become a member of two advisory committees. They are the Kellogg Foundation study grant for hospital based nursing homes at University Hospitals, and the "Project Six" study of the Community Services Demonstration Project of Central Colony for the mentally retarded in southwestern Wisconsin.

Doctor Allen also had an article on the use of isometric exercises in a geriatric treatment program published in the April GERIATRICS.

New at Marshfield Clinic

Dr. Louis J. Ptacek, pediatric neurologist, and Dr. Marten Geitz, orthopedic surgeon, have recently joined the staff of the Marshfield Clinic.

Doctor Ptacek was a 1952 graduate of Marquette University School of Medicine and interned at St. Joseph's Hospital in Milwaukee. He was the medical director at the Southern Wisconsin Colony and Training School at Union Grove from 1955–1960. He then served his residency at the University of Wisconsin Medical School and was named a clinical instructor at the University.

Doctor Geitz, a Dutch citizen but a native of Sumatra, received his medical degree in 1955 from the University of Utrecht, Holland, and completed his residency in October at the Mayo Clinic.

Dr. Rosekrans Speaks on USSR Tour

Dr. Sarah Rosekrans, Neillsville physician, gave a talk November 8 to the Wausau Woman's Club on her recent tour of the USSR.

Conduct Cancer Program

Drs. John Riordan, M. G. Rice, and *Albin Sowka* conducted a public education program on uterine and breast cancer October 25 in Stevens Point at a meeting sponsored by the Portage County Unit of the

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Physicians whose names appear in italics are members of the State Medical Society.

American Cancer Society, of which Doctor Riordan is chairman.

Dr. Kline Attends AOA Meeting

Dr. Carl L. Kline, Wausau psychiatrist and medical director of the Marathon–Langlade County Guidance Center, recently attended the board and committee meetings of the American Orthopsychiatric Association in New York City.

Dr. Buesseler Takes Paratroop Training

Dr. John A. Buesseler, 1944 graduate of the University of Wisconsin Medical School and a former practitioner in Madison, recently completed three week airborne training at the Army Infantry School in Fort Benning, Georgia. The 46 year old reservist colonel underwent the rigorous paratroop training with 560 other men, most of whom were half his age. Doctor Buesseler is professor of ophthalmology and chief of eye surgery at the University of Missouri Medical School.

Compares U. S., Puerto Rican Practices

Dr. Julio de Arteaga, who has been practicing in Brillion for seven months, spoke to the Brillion Woman's Club October 26 on the comparison of medical practice in the U.S. and in his native Puerto Rico.

Public health officer in Puerto Rico for five years, Doctor de Arteaga explained that although there are many disadvantages to the system whereby the U.S. government pays the medical bills of 2,000,000 Puerto Ricans, the system has stamped out malaria and has curbed other diseases.

Three Join Monroe Clinic

Three physicians have recently been added to the Monroe Clinic staff. They are Drs. Mary V. Pratt, Michael M. Geldner, and his wife, Barbara Geldner.

Doctor Pratt completed her residency in ophthalmology in September at the University of Wisconsin Medical School, where she received her medical degree in 1961. Her internship was served at Rhode Island Hospital in Providence.

Dr. Michael Geldner, neurosurgeon, and his wife, ophthalmologist, are natives of Poland. They received their medical degrees at the University of Warsaw School of Medicine in 1950 and served their residencies at the University Hospital in Warsaw. They were on the staff of this hospital for seven years until Dr. Michael Geldner was appointed Chief Neurosurgeon at the Tel Aviv government hospital, where Dr. Barbara Geldner became an attending physician in the Dept. of Ophthalmology.

In 1961 Dr. Michael Geldner came to the US to study at the Albert Einstein College of Medicine and at Montefiore Hospital in New York. He was joined by his wife in 1962, when she took an internship at Middlesex General Hospital in New Jersey.

Dr. Michael Geldner recently completed work as Research and Clinical Associate in the Dept. of Neurosurgery at New York University Medical Center. Dr. Barbara Geldner previously was senior staff physician at the Roosevelt Hospital in Matuchen, New Jersey.

Dr. Delfs Named to Marquette Chair

Dr. Eleanor Delfs, professor of gynecology and obstetrics at Marquette University School of Medicine, has been named the first holder of the Patrick J. and Margaret G. McMahon chair in those fields.

The chair was established in June 1964 with a gift of $203,205 from the late Dr. Joseph P. McMahon, the school's first professor of obstetrics. The chair is named in honor of his parents.

Doctor Delfs joined the Marquette medical faculty in 1963, the first woman to become a full professor at the school.

A 1935 graduate of Johns Hopkins Medical School, she was a house officer in gynecology and obstetrics from 1935–1938 at Johns Hopkins Hospital. A research fellow in obstetrics at the school there from 1938–1940, she continued on the faculty and became an associate professor in obstetrics in 1950.

Dr. Thomas in New Prentice Clinic

Dr. Griffith L. Thomas, who has been practicing in Prentice since July 6, moved into the new Prentice Clinic November 15. Doctor Thomas, a graduate mechanical engineer before entering medical school, designed the clinic which he will purchase from the corporation that built it.

Dr. Grand Arranges Teaching Clinic

Dr. C. A. Grand was in charge of arrangements for a teaching clinic October 21 in Ashland. A group of Mayo Clinic physicians made up a panel for discussions on internal medicine and allergy, hematology, and pediatrics. The clinic was sponsored by Eli Lilly Co., Indianapolis.

Drs. Lubitz, Pecarski Appointed

Dr. Joseph M. Lubitz, Milwaukee pathologist, has been appointed to the medical active staff of Memorial Hospital, Oconomowoc; and Dr. Miodrag Pecarski, Dousman general practitioner, to the medical courtesy staff.

Formerly a consulting staff member, Doctor Lubitz has been associated with the hospital as director of laboratory since 1963. Doctor Pecarski, a native of Yugoslavia, began his Dousman practice in September.

Dr. McSweeny at Beloit

Dr. Austin J. McSweeny, adult psychotherapist and marriage counselor, began practice in October at Beloit. He had been practicing in Janesville since 1957.

(Photo courtesy of THE CAPITAL TIMES)

THE STATE MEDICAL SOCIETY of Wisconsin presented a community achievement award to Madison General Hospital in October. The award cited the hospital as an "outstanding example of how the medical profession and hospital, working together provide superior patient care and public service in fulfillment of the American tradition." Shown here with the award are (left to right) Gordon N. Johnsen, administrator of the hospital; Dr. *E. J. Nordby*, a member of the hospital staff and board; Dr. *J. H. Haughton*, Wisconsin Dells physician and president of the State Medical Society; and John B. Secord, president of the hospital association.

Remodels Emergency Facilities

University of Wisconsin Hospitals in Madison has recently remodeled its emergency facilities to provide space for new equipment and better service. The number of emergency patients has risen sharply in the past five years.

Madison Hospital Awarded Grant

Madison General Hospital has been awarded a $239,115 grant from the John A. Hartford Foundation, Inc., New York, to support a three year program of recognition, control, and prevention of serious consequence of infections.

An initial grant of $234,125 in 1961 established the John A. Hartford Research Laboratory at the hospital. The laboratory is under the direction of *Dr. J. D. Cherry*, Assistant Professor of Pediatrics at the University of Wisconsin Medical School. Doctor Cherry's research emphasis has been in virology, particularly the study of virus infections of children.

BOOKLET: RHEUMATIC FEVER

Control of rheumatic fever is discussed at length in a 24-page booklet offered by Wyeth Laboratories. Entitled "Diagnosis, Therapy and Prophylaxis of Streptococcal Pharyngitis in the Control of Rheumatic Fever," the booklet describes rheumatic fever as a continuing problem and "a major catastrophe of childhood."

The importance of accurate diagnosis of streptococcal pharyngitis is discussed from an extensive list of 64 references. Diagnostic methods are outlined along with treatment of choice for controlling strep infection and preventing rheumatic fever.

Copies of the booklet are available for medical and hospital personnel from Wyeth representatives or from Wyeth Laboratories, Box 8299, Philadelphia, Pa. 19101.

* * *

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NEW INSURANCE COVERAGE AVAILABLE TO STATE PHYSICIANS

The Council Committee on Economic Medicine has been busy examining the various forms of insurance in effect for the members of the State Medical Society of Wisconsin with the objective in mind of determining whether any major improvements could be made.

We were advised that we could obtain Business Overhead Expense Insurance for our members on a group basis. By utilizing the group approach, we are able to save our members from 30% to 50% of the cost when compared to an individual policy.

Business Overhead Expense Insurance is a form of protection whereby a physician can provide for the payment of all monthly business expenses in the event he should become disabled. The expenses include such items as rent, utilities, laundry, employees' salaries, taxes, insurance premiums, accountants' fees, depreciation and other fixed and normal expenses as are customary.

The committee's examination of several insurance companies' plans has led us to endorse one. You will be receiving information with respect to it very soon and we urge you to be on the lookout for the material explaining the details.—P. B. BLANCHARD, M.D., *Committee Chairman*

A 1949 graduate of Loyola Medical School in Chicago, he interned at Buffalo City Hospital, N.Y., and served his residency at Buffalo VA Hospital. Then he studied under a fellowship at the Mayo Clinic.

Dr. Hopkins Elected

Dr. G. J. Hopkins has been elected president of Hudson Memorial Hospital in Hudson, succeeding *Dr. G. E. Bourget. Dr. M. A. Cornwall* is vice president and *Dr. M. G. Anderson*, secretary.

Dr. McAfee Named Chief of Staff

Dr. George D. McAfee has been named chief of staff of Sacred Heart Hospital, Eau Claire, succeeding *Dr. Thomas E. Kilkenny*. Other new officers are *Dr. Karl Walter*, vice president, and *Dr. R. C. Frank*, secretary-treasurer.

Dr. Klopf Joins Medical Group

Dr. Howard M. Klopf has joined the staff of the Falls Medical Group in Menomonee Falls. A graduate of Marquette University School of Medicine, he was formerly chief of staff at St. Luke's Hospital in Milwaukee and head of the general practice departments at Trinity Hospital and West Allis Hospital.

Doctor Klopf is president of the Wisconsin Academy of General Practice and past president of the Milwaukee Academy of General Practice.

Dr. Petersen Named Assistant Dean

Dr. John R. Petersen, assistant professor of medicine at Marquette University School of Medicine, has been appointed assistant dean of the school. He will relinquish his duties as assistant director of medicine at Milwaukee County General Hospital, but will remain on the staff and continue his duties as assistant professor of medicine.

A native of La Crosse, Doctor Petersen is a 1954 graduate of the University of Wisconsin Medical School. He interned at Philadelphia General Hospital and took residency training in internal medicine at Milwaukee County General.

200 Physicians Take Telephone Course

Without leaving their own communities, over 200 Wisconsin physicians began a University of Wisconsin postgraduate medical course November 1. The new course is being conducted via telephone conference circuit.

The experimental program, linking doctors in 18 communities with the University, offers lectures and discussions one hour each week for 24 weeks. Faculty are physicians from the University Medical Center and Marquette University School of Medicine.

Doctors taking the course hear a half hour telephone lecture, with accompanying color slides, at conference rooms in their community hospitals. Then they are able to question the lecturer and hold discussions via the telephone circuit.

The program was developed by the Extension division's newly established department of postgraduate medicine and the Committee on Continuing Education of the Medical Center.

Dr. Wendt Elected President

Dr. F. A. Wendt has been elected the new president of Watertown Memorial Hospital in Watertown. *Dr. Robert Baldwin* is vice president, and *Dr. E. P. Schuh* is secretary-treasurer.

Speak on Birth Defects

Three Wisconsin physicians addressed clubwomen and paramedical personnel from throughout the state October 21 in Milwaukee at a Symposium on Birth Defects.

Dr. John Opitz, assistant professor of medical genetics and pediatrics at the University of Wisconsin Medical School and acting director of the National Foundation Birth Defects Clinical Study Center at the University, spoke on the hereditary factors in abnormal children.

Dr. Shimpei Sakaguchi, assistant clinical professor of surgery at Marquette University School of Medicine, discussed the causes of defects.

Dr. William Gallen, director of Fairchild Cardiac Study Center at Milwaukee Children's Hospital, spoke on congenital heart malformations.

Dr. Tenney Speaks, Named Representative

Dr. H. Kent Tenney, Jr., clinical professor emeritus of pediatrics at the University of Wisconsin Medical School and pediatrician with the State Department of Public Instruction in Madison, spoke October 21–22 in Madison at the 16th annual convention of the Wisconsin Association of Licensed Practical Nurses.

Doctor Tenney also spoke on "Ways Parents Can Help the Child's Healthy Emotional Growth" November 4 at the Madison Vocational, Technical and Adult schools. The lecture was part of a series on "Guiding Your Child: The First Five Years", sponsored by the Dane County Mental Health Center.

On November 8, Doctor Tenney was appointed to represent the Bureau for Handicapped Children on Madison's special education advisory committee.

Dr. Houghton Honored

Dr. John H. Houghton, veteran Wisconsin Dells physician and president of the State Medical Society of Wisconsin, was honored by the Wisconsin Dells Kiwanis Club November 8 for his 33 years of service.

Doctor Houghton received a citation and gave a few of his impressions of the White House health conference he attended November 3–4. He was

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Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
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among 850 persons invited by President Johnson to the conference to gather "the best minds and the boldest ideas to deal with the pressing health needs of the nation."

The topics under discussion at the conference included health professions education, health care, and health protection. Provisions of the Medicare program were also studied.

Photo courtesy WISCONSIN DELLS EVENTS

Dr. J. H. Houghton of Wisconsin Dells, president of the State Medical Society, is shown at the left above, receiving the Kiwanis Club citation from Robert Bestul, Kiwanis Club president.

Drs. Wasserburger, Ylitalo Speak

Drs. Richard H. Wasserburger and *William H. Ylitalo* were the featured speakers at a public heart forum November 3 at Richland Center. Doctor Wasserburger is chief of cardiology and professor of clinical medicine at the VA Hospital in Madison, and Doctor Ylitalo is a clinical instructor in pediatrics at the University of Wisconsin Medical School. Doctor Wasserburger spoke again November 10 to the Marinette County Medical Society. His subject was "Clinical Electrocardiography."

Receive Angiology Award

Three physicians recently received honors achievement awards from the Angiology Research Foundation, Inc. They are *Dr. Charles W. Crumpton*, professor of medicine and director of the cardiovascular research laboratory at the University of Wisconsin Medical School; *Dr. Marvin Wagner*, chief of surgery at St. Michael Hospital in Brown Deer; and Dr. Enrique Valdivia, associate professor of pathology at the University of Wisconsin Medical School.

* * *

FEW IF ANY new drugs or inventions have been commercially developed in countries which do not offer proper patent protection to the inventor.

Description: Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.
Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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Hygroton®
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The long-acting diuretic

1966 WISCONSIN

Jan. 20: "In Depth" teaching program, "Problems of Elderly Patients" (Surgery and Anesthesia), SMS headquarters, Madison.

Feb. 4–6: Annual scientific meeting, Wisconsin Psychiatric Association, The Abbey on Lake Geneva, Fontana.

Feb. 5: Annual educational symposium of the Wisconsin State Medical Assistants Society, State Medical Society headquarters, Madison.

Feb. 15–17: Mt. Telemark Medical Symposium and Ski Outing, Indianhead Chapter of the WAGP, Mt. Telemark Ski Chalet, Cable.

Feb. 16: "In Depth" teaching program, "Problems of Elderly Patients" (Dermatology and EENT), SMS headquarters, Madison.

Feb. 23: Postgraduate course, "The Problem Child—Medical and Psychological Aspects," in Eau Claire, sponsored by the Division on Nervous and Mental Diseases of the Commission on State Departments and supported by a grant from the Charitable, Educational, and Scientific Foundation of the State Medical Society of Wisconsin.

Mar. 9, 16, 23, 30: Marquette University School of Medicine, postgraduate course in hematology, Milwaukee.

Mar. 24: "In Depth" teaching program, "Problems of Elderly Patients" (Neurology), SMS headquarters, Madison.

Mar. 31–Apr. 2: University of Wisconsin Medical School, postgraduate program on "Viruses and Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 1: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 2: Wisconsin Thoracic Society, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 7, 14, 21, 28: Marquette University School of Medicine, postgraduate course on chemotherapy of infectious diseases, Milwaukee.

May 5–7: University of Wisconsin extension division, "Radiology and Pathology of Genitourinary System," Wisconsin Center, Madison.

May 10–12: State Medical Society, annual meeting, La Crosse.

May 21: Wisconsin Heart Association, 18th annual meeting, Wisconsin Center, Madison.

June 17: Wisconsin Academy of General Practice, Lederle symposium, Wausau Club, Wausau.

June 2–4: University of Wisconsin Extension Division, psychiatric program, Wisconsin Center, Madison.

1966 NEIGHBORING STATES

Mar. 21–Apr. 2: Department of Otolaryngology of Illinois Eye and Ear Infirmary and College of Medicine of University of Illinois at the Medical Center, Chicago, postgraduate course in laryngology and bronchoesophagology, at Illinois Eye and Ear Infirmary.

Mar. 5–6: First National Congress on Medical Ethics and Professionalism, AMA-sponsored, Pick-Congress Hotel, Chicago. (Rescheduled from Oct. 2–3, 1965.)

Apr. 28–30: Midwest Conference on Anesthesiology, Illinois Society of Anesthesiologists, Continental Plaza Hotel, Chicago.

1967 NEIGHBORING STATES

Oct. 2–6: Annual Clinical Congress, American College of Surgeons, at Chicago.

1966 AMA

Feb. 4–9: AMA Medical Education Congress.

June 26–30: AMA Annual Convention, Chicago.

Nov. 27–30: AMA Clinical Convention, Las Vegas.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Annual Cardiac Symposium

The Ninth Annual Cardiac Symposium will be held Jan. 28–29, 1966 in Phoenix, Arizona. The symposium is sponsored by the Arizona Heart Association in cooperation with the American Academy of General Practice, Arizona Chapter, which has approved these sessions for 10 hours post-graduate credit.

No registration fee will be charged for medical students, residents, or interns; however, everyone who attends must register whether or not a fee is required.

For further information, contact Dr. Richard J. Martin, Symposium Planning Committee Chairman, Arizona Heart Association, 2824 North 16th Street, Phoenix, Arizona 85006.

New Orleans Graduate Medical Assembly

The 29th annual meeting of The New Orleans Graduate Medical Assembly will be held March 7–10, 1966, at the Roosevelt Hotel, New Orleans.

Nineteen guest speakers will participate in the program, geared to both specialists and general practitioners. There will be 54 discussions on topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round table luncheons and technical exhibits.

This program is acceptable for 29 accredited hours by the American Academy of General Practice.

Following the meeting, the group will leave for a trip around the world, March 12-April 12. The itinerary includes Hawaii, Tokyo, Nikko, Kyoto, Nara, Hong Kong, Bangkok, New Delhi, Agra, Jaipur, and Cairo.

For information concerning the Assembly meeting and tour write Secretary, New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, Room 1528, New Orleans, Louisiana 70112.

Symposium on the Problem Child

An educational symposium on "The Problem Child—Medical and Psychological Aspects" will be held Feb. 23, 1966, in Eau Claire. This postgraduate program will be sponsored by the Division on Nervous and Mental Diseases of the Commission on State Departments and supported by a grant from the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Psychophysiological aspects, behavioral disorders in childhood—particularly those involving school, and adolescent psychology are among the topics to be covered in the case reviews, lectures and audience participation.

The symposium, which is limited to physicians, is acceptable for five accredited hours by the American Academy of General Practice.

American Cancer Society Symposium

The 1966 Scientific Session of the American Cancer Society will be held May 11, 1966, at the St. Francis Hotel, San Francisco.

This symposium, which will present advances in the diagnosis and treatment of the common cancer sites in this country, is open to all members and students of the medical and dental professions. There is no advance registration or registration fee.

Guest speakers on the program will be Dr. Leopold G. Koss, Memorial Hospital for Cancer and Allied Diseases, New York City, "The Present Status of Cytology in Uterine Cancer"; Dr. Tommy N. Evans, Wayne State University School of Medicine, "The Optimum Management of a Patient with a Positive Cervical Cytology Report"; Dr. H. Marvin Pollard, University of Michigan Medical Center, "Current Procedures in the Detection and Diagnosis of Colon and Rectal Cancer"; Dr. J. Englebert Dunphy, University of California School of Medicine, "Modern Treatment of Colon and Rectal Cancer"; Senator Maurine B. Neuberger, "The Control of Cigarette Smoking in the USA"; Dr. Thomas Carlile, The Mason Clinic, Seattle, "The Early Diagnosis of Lung Cancer"; Dr. Thomas W. Botsford, Harvard Medical School, "Advances in the Early Diagnosis of Breast Cancer"; Dr. Robert C. Hickey, University of Wisconsin Medical Center, "The Breast Cancer Treatment Controversy"; Sol Silverman, D.D.S., University of California School of Dentistry, "Oral Lesions of Neoplastic Significance and Oral Cancer"; Dr. Arthur G. James, Ohio State University Medical Center, "Management of Oro-Pharyngeal Cancer"; Dr. Herbert L. Traenkle, University of Buffalo School of Medicine, "Early Recognition and Diagnosis of Skin Cancer"; Dr. Richard H. Jesse, Anderson Hospital and Tumor Institute, Houston, "The Treatment of Skin Cancer"; and Paul Wiess, Ph.D., University of Texas Graduate School of Biomedical Sciences, "Premises and Prospects in Cancer Research."

For further information, write Dr. Roald N. Grant, Director of Professional Education, American Cancer Society, Inc., 219 East 42nd Street, New York, New York 10017.

State Medical Assistants Annual Meeting

The Wisconsin State Medical Assistants Society will hold its annual educational symposium February 5 at the State Medical Society headquarters in Madison. Following the 8 a.m. registration, a welcome will be extended by Miss Alice Roelse, president; Dave Reynolds, State Medical Society; and Mrs. Warren Knowles, Madison.

Speakers on the program will be Sister M. Alexius Wagner, Edgewood College, Madison, "The Importance of YOU—The Medical Assistant"; William Hansen, Clintonville, "From a Patient's Viewpoint"; Mrs. Elvera Fischer, CMA, President-Elect, Chicago, "The AAMA Story"; and Oscar Gaarder, Madison, "The Assistant's Role in the Medical Office."

NEW BOOKLET: MENTAL HEALTH RESEARCH FINDINGS 1963

Research results reported to the National Institute of Mental Health during 1963 are summarized in a new publication issued by the Public Health Service of the U. S. Department of Health, Education, and Welfare.

Prepared by the Program Analysis Section of the NIMH Research Grants Branch, this publication is one of a series designed to disseminate the findings of the Institute's nearly 2,000 investigators in its research grants program.

Single copies of "Mental Health Research Findings 1963," Public Health Service Publication No. 1136, can be obtained without charge from the Public Health Service, Washington, D. C. 20201. Multiple copies can be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, for 25 cents each, with quantity rates available for orders exceeding 100 copies.

WILLIAM OSLER MEDAL STUDENT ESSAY CONTEST

The William Osler Medal of the American Association for the History of Medicine is awarded for the best unpublished essay on a medico-historical subject written by a student in one of the medical schools in the United States or Canada. All students who are candidates for the degree of Doctor of Medicine, or who graduated in 1965, are eligible. This medal, first awarded in 1942, commemorates the great physician, Sir William Osler, who stimulated an interest in the humanities among students and physicians alike.

Essays should demonstrate either original research or an unusual appreciation and understanding of a medico-historical problem. Maximum length is 10,000 words. The prize-winning essay will be submitted to the Editorial Committee of the Association, which may recommend it for publication in the *Bulletin of the History of Medicine.*

Essays must be submitted by March 23, 1966, to the Chairman of the Osler Medal Committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois 60611.

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Role of Roentgen Therapy in Management of Degenerative Joint Disease

By G. D. VI GARIO, M.D., H. W. WIRKA, M.D. and HALVOR VERMUND, M.D., Madison, Wisconsin

■ THE DEGENERATIVE joint diseases (osteoarthritis, arthrosis, spondylarthrosis) constitute the most common articular disorders among rheumatic ailments and remain important unsolved medical problems.[1,2] Disability from this disease greatly exceeds that from other specific chronic diseases and costs society staggering amounts in medical care and lost wages.[2]

The degenerative processes which affect cartilage and bone with formation of the well-known hypertrophic changes around the margins of the articular surfaces are so common in elderly people that they may be considered a natural biologic process of senescence.[1] Symptoms of pain, swelling, decreased mobility, and crepitation develop as a result of acute or chronic traumas which provoke inflammatory changes in the synovia and the joint capsule. Atrophy and contracture of muscles and deformity account for much of the invalidism.

Roentgen therapy is still used extensively at many hospitals as an adjuvant to the medical management of degenerative joint disease, and to a large number of patients offers good palliation in terms of relief of pain, lack of objectionable side effects, and simplicity of application. According to current theory the irradiation acts through mechanisms which induce hyperemia, promote absorption of inflammatory infiltrates and exudates, and relieve pressure on sensory nerve endings.

The resulting analgesia and decreased swelling of the soft tissues aid in restoring a greater range of motion of the involved joints, even though the basic roentgenologic changes of atrophy of cartilage, sclerosis of juxta-articular bone, and marginal osteophytes persist.[3]

It is the purpose of this report to evaluate the results of roentgen therapy at the University of Wisconsin Hospitals and on the basis of a review of the literature to analyze the role of radiotherapy in the general medical management of osteoarthritis.

Material. The records of a group of 107 consecutive patients, mostly referred from the Division of Orthopedic Surgery and treated with roentgen rays during the years 1958–1964, were analyzed. All patients had the diagnosis of degenerative joint disease of the spine, hips, or knees made by physical and roentgenologic examination, and the results were assessed from one to three months after the last treatment.

From the Sections of Radiotherapy and Orthopedic Surgery, University of Wisconsin Medical School.

Presented before the 124th Annual Meeting of the State Medical Society of Wisconsin, May 4, 1965, Milwaukee.

Doctor ViGario was a Resident in Radiotherapy from Jan. 1 to Dec. 31, 1964. Doctor Wirka is a Professor of Surgery and Doctor Vermund is a Professor of Radiology.

TABLE 1—*Results of One Course of Roentgen Therapy in Osteoarthritis*

	Excellent	Satisfactory	Fair	No Response	Total
Cervical spine	7	4	5	1	17
Thoracolumbosacral	14	24	6	10	54
Hip	4	5	2	4	15
Knee	4	10	5	2	21
TOTAL	29	43	18	17	107
PERCENTAGE	27	40	17	16	100

TABLE 2—*Results of Repeat Roentgen Therapy in Osteoarthritis*

	Excellent	Satisfactory	Fair	No Response	Total
Cervical spine		1	1		2
Thoracolumbosacral	2	3		4	9
Hip			4	1	5
Knee	3	1			4
TOTAL	5	5	5	5	20

Technic. Roentgen therapy at 250 kv with half-value-layers from 1 to 3 mm of copper was employed with generous fields encompassing the painful and tender joints and periarticular tissues. The hip and knee were treated through anterior, posterior, and lateral ports and the spine through single posterior fields. A dose of 150 to 200 roentgen (R) in air was given either daily or every other day for a total of three, or occasionally four, treatments. The majority of the patients received a total dose of 600 R in air. If, on routine follow-up examination four to six weeks later, pain and tenderness persisted to a significant degree, a repeat course of roentgen therapy was given. Occasionally a third course was administered.

No skin reactions or other objectionable sequelae were observed.

Results. Results were scored as *excellent* when the patient became entirely free of pain or had only minor residuals such as slight morning stiffness or mild transitory pain precipitated by changes in the weather, heavy work, or exercise.

Results were considered *satisfactory* when the patient reported definite alleviation of symptoms such as pronounced decrease in pain and tenderness and improved range of mobility. Patients with mild persistent pain relieved by an occasional aspirin or equivalent analgesics were accepted into this category.

Results were classified as *fair* when there was only a slight amount of pain relief with considerable residual tenderness and stiffness.

If the patient reported no relief of pain the result was scored as *no response.*

The patient was placed in the lower category of therapeutic effectiveness if the findings left any doubt about the classification.

TABLE 3—*Results Obtained by Different Authors With Roentgen Therapy of Osteoarthritis*

	No.	Free of Symptoms	Marked Improvement	Improved	No Response
v. Pannewitz[3]	2,555	562 = 22%	1,048 = 41%	588 = 23%	357 = 14%
Renck[10]	1,987	907 = 46%	593 = 30%	278 = 14%	209 = 10%
Bakke[21]	333	99 = 30%	115 = 34%	64 = 19%	55 = 17%
Baensch[22]	288	66 = 23%	86 = 30%	58 = 20%	78 = 27%
Fried[8]	228	78 = 34%	85 = 37%	46 = 20%	19 = 9%
Kuhns[13]	118	6 = 5%	10 = 9%	69 = 58%	33 = 28%
Ochsner[23]	23	1	12	7	3
Total	5,532	1,719 = 31%	1,949 = 35%	1,110 = 20%	754 = 14%

	No.	Free of Symptoms	Improved	No Response
Hess[11]	664	84 = 13%	291 = 44%	289 = 43%
Cocchi[5]	582	147 = 25%	263 = 45%	172 = 30%
Kahlmeter[24]	63	19	33	11
Total	1,309	250 = 19%	587 = 45%	472 = 36%

	No.	Marked Improvement	Slight Improvement	No Response
Kersley[4]	373	123 = 33%	65 = 17%	185 = 50%

	No.	Improved	No Response
Gersfelt[12]	643	436 = 68%	207 = 32%

As summarized in Table 1 the results were termed excellent in 27% of the cases with an additional 40% obtaining satisfactory results. Fair response was reported by 17% and only 16% of the patients obtained no relief.

A second series of roentgen therapy was administered to a group of 20 patients, the majority of whom had reported only fair or no relief of pain after the first course (Table 2).

Excellent response was reported by 5 patients and satisfactory relief of symptoms by an additional 5, so that worthwhile palliation was recorded in 50% after the second course. Only 5 patients remained refractory.

After treatment of the spine and the knee the incidence of excellent or satisfactory response was similar, varying from 65% to 70%, but it seemed somewhat lower after irradiation of the hip (60%). Similarly, the results of retreatment were poorer in the latter group, with 4 of 5 patients reporting only fair relief and one no response.

The patient's age did not appear to have an influence on the results; 38 of 56 patients (68%) above the age of 60 years compared to 34 of 51 (67%) of those below this age reported excellent or satisfactory response.

Discussion. The results obtained in the current series are similar to those reported by others from many institutions in different countries using varying dosages and technics (Table 3). In an accumulated series of 5,532 cases, 31% obtained marked improvement. Only 14% of the cases were refractory. In a second series of 1,309 cases, 19% became free of symptoms and an additional 45% improved. The least favorable results were obtained by Kersley,[4] who reported that 50% of 373 cases were refractory.

The results obviously depend upon the composition of the patient material, and many factors have been shown to influence them:

(a) Duration of Symptoms: The sooner patients receive roentgen therapy after onset of pain the better the results.[3,5] Thus, von Pannewitz found that 83% of patients with symptoms of less than one month's duration showed considerable improvement or freedom of symptoms as compared to 50% of those whose symptoms had lasted for more than one year.[3] These results would seem to support the recommendation that patients should be referred promptly for roentgen therapy without losing time with other and less effective methods of therapy. Adjuvant physical and orthopedic measures to mobilize joints, strengthen muscles, and prevent deformities are often instituted simultaneously.[6]

TABLE 4—*Incidence of Response After Roentgen Therapy of Degenerative Joint Disease*

	Knee	Spine	Hip
Bakke*[21]	103/ 148 = 70%	65/103 = 63%	46/ 82 = 56%
Fried*[8]	101/ 128 = 79%	6/ 9 = 67%	4/ 10 = 40%
Renck*[10]	950/1230 = 77%	180/230 = 78%	350/527 = 70%
Cocchi†[5]	132/ 188 = 70%	104/153 = 68%	73/107 = 68%
Gersfelt†[12]	229/ 290 = 79%	100/147 = 68%	64/126 = 51%
Hess†[11]	220/ 366 = 60%	99/159 = 63%	17/ 70 = 24%
Kahlmeter†[24]	23/ 25 = 92%	----------	5/ 14 = 36%
	1758/2375 = 74%	554/801 = 69%	559/936 = 60%

*Much improved or free of pain.
†Improved or free of pain.

(b) Age: The age of the patient did not seem to influence the results in the present series. This is in accordance with the experience of others,[4] although some authors have found that very old patients respond less favorably.[7]

(c) Secondary Arthritis: Patients with osteoarthritis which has developed on the basis of previous infections, malalignment due to fractures, aseptic necrosis, or other gross abnormalities respond less favorably. Only 55% of patients with secondary osteoarthritis treated by von Pannewitz responded satisfactorily as compared to 71% of those with primary osteoarthritis.[3] Mechanical disalignment is frequently a continued source of irritation and results in inflammatory reactions with a high rate of recurrence of clinical symptoms.

(d) Severity of Radiographic Findings: Patients with roentgenologic findings of advanced degenerative joint disease of the spine responded less favorably. This was illustrated by the finding reported by von Pannewitz that only 24% of the patients in such a group became free of pain or were considerably improved as compared to 92% of those with only minor roentgenologic changes.[3] In patients with osteoarthritis of the extremities, however, the difference in response rate as related to the degree of roentgenologic change was much less.

(e) Locations of Osteoarthritis: Degenerative joint disease involving the knees seems to respond better to roentgen therapy than when it affects the spine or the hips.

Thus, the favorable response rate from irradiation in a compilation of 2,375 cases involving the knee was 74%, in 801 cases involving the spine 69%, and in 936 cases affecting the hip 60% (Table 4). This compares with the results obtained in our own series in which excellent or marked improvement was obtained in 69%, 67%, and 60% of lesions involving the spine, knees, or hips respectively (Table 1). The hip lesions therefore seem to be the least responsive. Kersley[4] reported that roentgen therapy gave a better response in osteoarthritis of the thoracic than of the cervical or lumbar spine.

Duration of Remission. Relief of pain and associated increased mobility do not always occur immediately. On the contrary, many patients complain of increased symptoms after the first treatment. This is of no consequence as far as end results are concerned. Usually improvement is gradual, sometimes beginning weeks after roentgen therapy has been started. The patient should be instructed regarding this sequence of events.

Some patients report lasting improvement.[8,9] Renck[10] reported that of 1,304 cases, 83% remained free of recurrent symptoms for more than three years. Kersley[4] observed that 80% of patients who received adequate x-ray dosage maintained their improvement for more than one year. Hess and Bonmann[11] found that 102 of 267 cases that were improved or free of pain developed recurrent symptoms within six months (38%). On the other hand, 97 patients who had obtained no initial relief were improved after repeated roentgen therapy. Gersfelt[12] reported that 241 of 436 patients who had obtained symptomatic relief remained improved for more than six months (55%).

Technic of Roentgen Therapy. Even though there appears to be unanimity of opinion regarding the beneficial effects of roentgen therapy on the clinical symptoms of degenerative joint disease, there is no agreement regarding what constitutes optimal dosage and intervals between treatments.

Von Pannewitz[3] recommended 100 R* to the hip or spine and only 50 R* to the joints of the extremities, and repeated the treatments at weekly intervals for five to eight times. Since these dosages produced only limited relief, a second series was commonly started after six to eight weeks and if necessary a third series after an interval of three months.

Fried[8] recommended 120 to 150 R† initially, but in cases obtaining good relief gradually decreased the doses at increasing intervals. If no improvement occurred after the first treatment, the second dose was increased by 40 R and shorter intervals between treatments were instituted.

Kersley[4] obtained better results with higher doses. A series of 429 cases was divided into four groups as follows: A control group received no roentgen therapy but did receive physiotherapy with 21% (12 of 56 patients) reporting marked relief of symptoms. A second group received 500 R in small fractions twice weekly over three to four weeks and 26% (23 of 89 patients) obtained a similar response. A third group was treated with 750 R to 1,000 R over the same period of time with 32% (59 of 182 patients) reporting similar improvement. A fourth group was irradiated with 1,500 R to 2,000 R over three to four weeks and 40% (41 of 102 patients) reported marked improvement.

The author emphasized the importance of adjuvant therapy designed to spare yet mobilize the joints and prevent muscle atrophy. The patients who take advantage of the analgesia provided by roentgen therapy to misuse the joints, ultimately develop aggravation of symptoms. In obese patients with osteoarthritis of knees or hips, weight reduction and exercises to strengthen the muscles are indicated. Heat, hydrotherapy, and massage may ease pain in acute cases, but heat may be poorly tolerated in advanced cases.[4,7] Gersfelt[12] estimated that only 25% of his patients obtained relief of pain from physiotherapy alone. Renck[10] took an even more pessimistic view and reported no added benefit from supplementary physiotherapy.

In this country, Kuhns and Morrison[13] recommended 1,200 R over a period of three weeks but reported only 47% (56 of 118 patients) with marked or moderate improvement.

Gersfelt[12] found that treatment of osteoarthritis of the knee with 1,800 R gave no better results than were obtained with 500 R delivered in 4 fractions of 125 R at two to three days' interval. The latter dose was considered optimal.

* 180 kv, 0.5 mm copper filter.[25]

† 160 to 180 kv, 0.5 to 1.0 mm aluminum filter.

Kersley[4] studied 92 joints with symmetrical degenerative joint disease and arrived at different conclusions: he found that the higher doses of 750 R to 2,000 R were nearly twice as effective as the lower doses of 500 R or less.

It is our impression that it is frequently unnecessary to deliver more than 600 R/a to joints with osteoarthritis, since excellent pain relief may be achieved with moderate doses. However, the slow weekly or biweekly schedule of therapy[3,14] may be difficult to complete in patients who have to travel over long distances.

The Psychotherapeutic Aspects. There is no doubt about the fact that many patients with arthritis obtain good or even excellent relief of pain from simple rest with or without adjuvant physiotherapy. Striking illustrations of this effect have been provided by Plenk,[15] who applied placebo treatments in acute bursitis, and by Smyth et al.,[16] who in a series of patients with rheumatoid arthritis found that critical evaluation of the natural remission rate in the control group reduced what might have been considered an 80% response rate from therapy to less than 30%.

Kuhns and Morrison,[13] however, found little effect from placebo therapy in a series of 10 patients with symmetrical osteoarthritis of both knees. Only one patient reported that the knee was improved after placebo therapy and no objective improvement was found in any of the 10 sham-irradiated joints, while subjective improvement was reported in 8 and objective improvement in 7 of the 10 irradiated knees.

Contraindications. Irradiation of lumbosacral and pelvic areas should be avoided in premenopausal women, since ovarian function may be suppressed.

Great caution must be exercised in the treatment of joints close to the gonads of patients in the reproductive period of life so as to avoid mutations and other genetic effects. Fortunately most patients with osteoarthritis belong to the older age group.

Prolonged radiotherapy in excess of three courses is rarely indicated and might result in undesirable radiation sequelae.

Objective Evidence for Radiation Effects on Osteoarthritis. Most of the evidence regarding the effects of radiotherapy on degenerative joint disease is based on statistical evaluation of data collected from analysis of subjective symptoms and is therefore subject to all the errors and pitfalls inherent in such evaluation. Good objective evidence is hard to find. However, Horwitz and Dillman[17] performed biopsies on the knee joints of two patients with nonspecific effusion before and after 2,580 to 3,010 R/a of roentgen therapy and found that the irradiation had resulted in disappearance of the edema of the synovia, increase in fibrous tissue, and thickening of vessel walls with obliteration of lumina of smaller vascular channels. There were still numerous perivascular collections of chronic inflammatory cells present in the subsynovial tissues. Both patients obtained good clinical response.

Interesting evidence has also been published in the veterinary medical literature on the results of radiotherapy of arthritic conditions in race horses.[18–20] Most of these conditions were chronic, the horses became lame and refused to run. The diagnosis was made roentgenologically with demonstration of arthritic changes around the radiocarpal, carpal, metacarpal, metatarsal, or sesamoid joints with periarticular proliferation or periosteal new bone formation in the majority of the cases and occasionally with soft tissue calcification.

Treatments were given with orthovoltage x-rays or with Cobalt60 radiation and the total dose varied between 800 and 1,500 R at the surface or at 1 to 2 cm depth in one to three fractions. After treatment the horses were allowed to rest in a stall for 60 to 90 days before regular training was reinstituted.

The results were termed good when the horse could be returned to racing and appeared sound, and fair when there was a favorable though temporary response.

In a series of 39 horses irradiated the results were good in 24 (61.5%), fair in 7 and poor in 8.[18] This compared with the results in an earlier series of 111 thoroughbreds[20] in which the results were good in 67 (60%), fair in 18, and poor in 26.

Summary and Conclusions. The results of roentgen therapy in a series of 107 patients with degenerative joint disease involving spine, hips, and knees were analyzed. The response was excellent in 27%, with an additional 40% obtaining satisfactory and 17% fair relief, while 16% remained refractory. When a second series of x-ray

therapy was delivered to 20 patients who had shown poor initial response, 10 of them obtained excellent or satisfactory pain relief.

These results are discussed in view of evidence gathered from the literature and support the conclusion that roentgen therapy continues to play a significant role in the medical management of degenerative joint disease.

1300 University Ave. (53706).

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BROCHURE: THE HOSPITAL LIBRARIAN

A new recruitment brochure, "The Hospital Librarian," prepared by the Office for Recruitment of the American Library Association, is now available free from ALA. The publication outlines the types of library service provided in hospitals: for the hospital's medical program, for the patients, and for the school of nursing, and describes the work of the librarian responsible for providing these services. The new brochure also describes the educational requirements necessary to become a hospital librarian and the opportunities open to those entering the profession.

Individuals and libraries are being encouraged to order the leaflets through the ALA Office for Recruitment, 50 E. Huron St., Chicago, Ill., 60611. Limited copies are available at no charge, and quantity prices follow: 25 copies, $1.25; 50 copies, $2.25; 100 copies, $4.00; 250 copies, $9.25; 500 copies, $15.00; 1,000 copies, $28.00.

NEW PAMPHLET: A NEW CHAPTER IN FAMILY PLANNING

A New Chapter in Family Planning, a Public Affairs Pamphlet just released, discusses the latest developments in both attitudes and in methods. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016. The author is Elizabeth Ogg, who has also written other popular Public Affairs Pamphlets on family relations, psychology, and mental health.

A New Chapter in Family Planning stresses the contribution family planning can make to stable, responsible family life. This is reflected, too, in the fact that an increasing number of health and welfare departments now offer free choice of method, and that Congress recently appropriated money for birth control clinics in the District of Columbia.

As a special feature of the 1965 Annual Meeting of the State Medical Society, the Commission on Scientific Medicine invited Residents of Wisconsin hospitals to present papers in competition for a $100 cash award. Two such awards were granted—one designated as The William S. Middleton Lecture, the other as The Harry Beckman Lecture. Judges were: Ovid O. Meyer, M.D., Madison, member of the Commission on Scientific Medicine; Victor S. Falk, M.D., Edgerton, medical editor of the WISCONSIN MEDICAL JOURNAL; *and Norbert Bauch, M.D., Milwaukee, representing the Wisconsin Academy of General Practice. The two winning lectures are presented below.*

Use of Peritoneal Lavage in Experimental Pancreatitis

By LARRY C. CAREY, M.D., Milwaukee, Wisconsin

■ WHILE THE MORTALITY rate of pancreatitis has improved in recent years, the hemorrhagic form of the disease remains extremely lethal. Elliot[1] suggested that death in experimental pancreatitis could be avoided with the infusion of serum albumin. In clinical experience, however, patients die of pancreatitis even after adequate volume replacement. Anderson[2,3] showed that the combination of blood plus trypsin produced a lethal toxin. Thal[4] found that a vasoactive polypeptide was released in pancreatitis. This substance proved to be bradykinen or bradykinen-like.

Experience in our laboratory showed extensive fat necrosis and peritonitis with experimental pancreatitis. The following study was devised to determine the effect on mortality of treating experimental pancreatitis with peritoneal lavage.

Method. Adult mongrel dogs were chosen without regard to sex or weight. Anesthesia was accomplished with intravenous barbiturates. The abdomen was opened and the lesser pancreatic duct ligated and the omentum removed. Transduodenal cannulation of the greater pancreatic duct was then carried out and the duodenum closed. Through the cannula in the pancreatic duct, a mixture of 160,000 units of trypsin (Tryptar) and 6% sodium taurocholate was infused into the pancreas at 40 cm of water pressure. The volume of infusate was 20 ml in all cases. The trypsin and bile salt were dissolved in normal saline and buffered to a pH of 8.0 immediately before infusion. After the infusion had begun, a coin was flipped to choose whether the animal would be experimental or control. Following the infusion the pancreatic cannula was removed. In the experimental animals, large sump drains were placed in the right paracolic gutter and brought out through a right lateral stab wound. The abdomens were then closed in both groups.

Both groups of animals received 30 ml/Kg of normal saline intravenously at 8, 16 and 24 hours post-pancreatitis. In the experimental group, peritoneal lavage was performed through the sump drain with 1000 ml of Hartman's solution. The lavage was performed at 2, 4 and 6 hours post-pancreatitis. All fluid removed in excess of the lavage volume was replaced with intraperitoneal Hartman's solution after the last lav-

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From the Division of Surgery, Marquette University School of Medicine and the Allen–Bradley Medical Science Laboratory.

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Presented as the William S. Middleton Lecture at the Annual Meeting of the State Medical Society of Wisconsin, May 6, 1965, Milwaukee.

TABLE 1—*Serum Amylase*

	Pre-Pancreatitis	Post-Pancreatitis		
		4 hr	24 hr	48 hr
Control	1661	4660	6678	----
Experimental	2231	4000	5317	6937

Table 1. No significant correlation between amylase elevation and death.

age. All animals were given oxytetracycline (Terramycin), 250 mg in 50 ml of normal saline, intraperitoneally six hours post-pancreatitis.

The following laboratory tests were performed, before and four hours post-pancreatitis: serum pH, sodium, potassium, chloride, calcium, total protein and albumin-globulin ratio. In addition, hematocrit readings and serum amylases were done. Studies on the peritoneal fluid included sodium, potassium, chloride, pH, calcium, total protein, albumin-globulin ratio, and free hemoglobin. Animals were allowed water and food ad lib after 24 hours. Survival past three days was considered permanent.

Results. Nine control animals were done and eight died (88%). Ten experimental animals were done and five lived (50%). While no valid conclusions can be drawn from these figures, there were some interesting observations. The appearance of the dogs the morning after induction of pancreatitis was striking. Animals having undergone lavage were generally much better, were on their feet, appeared hungry, and had greater vigor. Even when they went on to die of pancreatitis, their early courses were of less prostration than their untreated counterparts.

Serum amylase had very little relation to severity of pancreatitis or death. We have since abandoned amylase determinations as a parameter of measurement in pancreatitis. Table 1 shows serum amylase values in control and experimental dogs. Table 2 shows the results of blood and peritoneal fluid chemistry determinations done on all animals pre-lavage. Of interest is the observation that the peritoneal fluid appears to be much the same as serum except in protein content. The alteration in protein content in the peritoneal fluid is in the albumin-like fraction. Total protein and fraction determinations were done by the biuret method. Electrophoresis was not done but will be necessary to elucidate the characteristics of this albumin-like substance. Free hemoglobin was also elevated both in serum and peritoneal fluid. We assume this finding to be due to hemolysis. Table 3 shows the alteration in hematocrit readings. Loss of plasma volume is reflected by a rise and again these changes are not greatly different in the control and the experimental animals.

TABLE 3—*Hematocrit Readings*

	Pre-Pancreatitis	Post-Pancreatitis		
		8 hr	24 hr	48 hr
Control	42.7	58.5	57.5	----
Experimental	44.7	55.5	54.3	54.0

Summary. Peritoneal lavage in experimental pancreatitis under the conditions of this study seems to offer some protection. While the mortality rate between lavage and non-lavage animals supports this thesis, the appearance of the animals 24 hours post-pancreatitis was even more striking. Chemistry determinations have not allowed any conclusions concerning the severity of the induced pancreatitis nor its probable lethality. Studies on the peritoneal fluid show it to be very similar to serum except in protein content. The protein is an albumin-like substance but its characteristics are not yet defined. The question arises as to the possible role of this protein in the toxicity of experimental pancreatitis.

TABLE 2—*Blood/Peritoneal Fluid 2 Hours Post-Pancreatitis (Averages)*

	pH	Na	K	Cl	Ca	Free Hgb	Alb	Glob
Blood	7.3	151	5.0	106	5.5	78	3.7	2.8
Peritoneal fluid	7.3	147	4.6	104	4.6	1350	6.8	2.6
Normals	7.35	143–152 mEq/L	4.0–5.2 mEq/L	100–105 mEq/L	4.9–5.9 mEq/L	25–40 gm %	2.5–4.0 gm %	2.5–4.0 gm %

Table 2. Only significant alterations are in protein content of peritoneal fluid and free hemoglobin.

Conclusions. Peritoneal lavage in experimental pancreatitis offers some protection from mortality. The peritoneal fluid in experimental pancreatitis contains an albumin-like substance in greater concentration than the serum. The role of this protein fraction in the toxicity of pancreatitis is unknown.

8700 West Wisconsin Avenue (53226).

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Anatomic Isolation and Perfusion of the Living Dog Brain

By M. B. GLOVER, M.D., D. D. GILBOE, M.D., and W. W. COTANCH, M.D. Madison, Wisconsin

■ THIS REPORT IS a brief description of the isolation and perfusion of the living dog brain with some of the preliminary metabolic findings. The project was initiated two and one-half years ago to find a tool suitable for study of normal cerebral fluid distribution and changes in its apportionment after administration of hypertonic solutions. Fluid distribution in the intact animal is studied with chemical substances which disperse in a single or well defined group of fluid compartments (i.e., intracellular, extracellular and intravascular). For accurate determination of fluid partition in a single organ the vasculature to and from the organ must be isolated from that of surrounding tissue.

The metabolism of the brain and the effect of various drugs on the central nervous system and its arteries have been investigated on brains reported to be completely isolated.[1–6] In none of these earlier preparations was there complete vascular isolation with perfusion and proof of viability. This has recently been accomplished.[7,8]

Studies of the complex collateral circulation of the dog's head[9,10] showed that complete surgical isolation was necessary (Figs 1 and 2). Initially we tried to ligate all extra and intracranial anastomotic branches, but radio iodinated serum albumin (RISA) studies showed a 20 to 30% cross contamination occurred between the pump oxygenator used to supply the brain and the blood in the general circulation. This indicated that it was not technically possible to isolate the brain in this manner due to the existence of inaccessible collateral circulation.

Next we investigated the possibility of maintaining a living brain while removing all extracranial structures. The absence of these tissues created the additional problem of defining criteria for brain viability. Metabolic activity was accepted as adequate proof of brain viability in the early work,[3] however, our preliminary studies with the isolated dog head[12] revealed that the metabolic and reflex activity persisted in the absence of electrocortical activity. We have used the normal or unchanged electroencephalogram (EEG) after isolation as the most sensitive indication of a living brain.

Doctor Glover is a Resident in Neurosurgery and an Instructor in Neurosurgery; Doctor Gilboe is a Biochemist and an Assistant Professor of Neurosurgery; Doctor Cotanch is a Resident in Neurosurgery; all of the Division of Neurosurgery, University of Wisconsin Medical School.

Supported in part by Grants NB02185 from the National Institute of Neurological Diseases and Blindness, 1–GS–135 from the National Institutes of Health and G4–211 from the Wisconsin Alumni Research Foundation.

Presented as the Harry Beckman Lecture at the Annual Meeting of the State Medical Society of Wisconsin, May 6, 1965, Milwaukee.

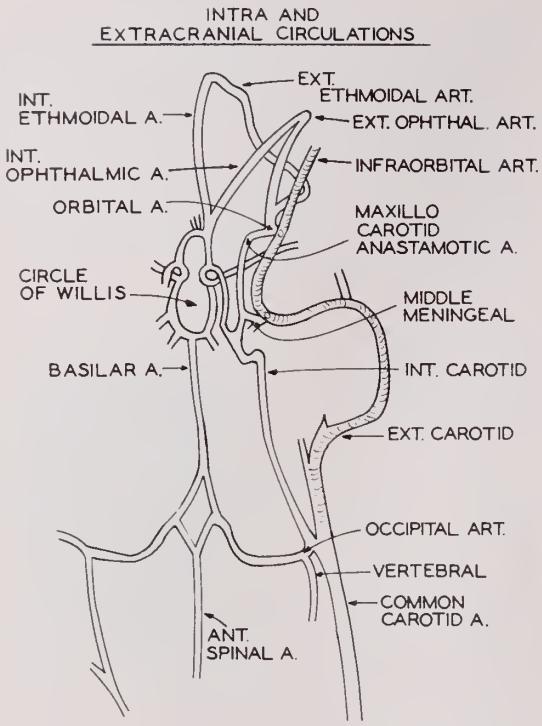

Fig. 1—Diagram of arterial supply of the dog brain.

Description. Seventy adult mongrel dogs (12–18 Kg) were used. All animals received 60 mg morphine sulfate and 20 mg/Kg sodium pentobarbital with supplementary doses of sodium pentobarbital given as necessary. The animals were ventilated through a cuffed endotracheal tube with a positive pressure respirator. The femoral artery and vein were cannulated to record blood pressure and to give intravenous medications.

A midline incision is made from the frontal sinuses to the spinous process of the 5th cervical vertebra. The temporal and paravertebral muscles to C3 are reflected exposing the frontal, temporal and occipital bones and lamina of C, 1, 2 and 3. Bilateral, frontal and parietal EEG recording electrodes are fixed in place with dental acrylic resin and a polyethylene tube is placed in the cisterna magna for measurement of cerebrospinal fluid (CSF) pressure. Thereafter, the blood pressure is monitored continuously while the EEG is checked periodically. The EEG is characteristic of barbiturate anesthesia. The animals are then turned to the supine position, a midline incision is made from the symphysis of the mandible to the sternum and a tracheotomy is performed. The esophagus and trachea are reflected anteriorly exposing the deep structures of the neck. The common carotids and internal maxillary arteries are mobilized, then all branches except the internal carotids and maxillo-carotid anastomotic arteries are ligated and cut. The paravertebral and anterior neck muscles are then dissected and reflected exposing the external auditory canals, temporomandibular joints and zygomatic arches. These structures are sectioned making it possible to remove the mandible, tongue, larynx, and contiguous tissues.

Next the orbital structures are severed at the base of the optic stalk and the maxilla and facial bones are removed with a Gigli saw leaving the intact cranium containing the vascularly isolated brain. Arterial blood is supplied via the internal carotid and maxillocarotid anastomotic arteries while all cerebral blood drains through the vertebral sinuses. Three mg/Kg of heparin are administered to the animals and siliconized stainless steel "T" tubes filled with heparinized blood are placed in both common carotid arteries and connected to a previously primed

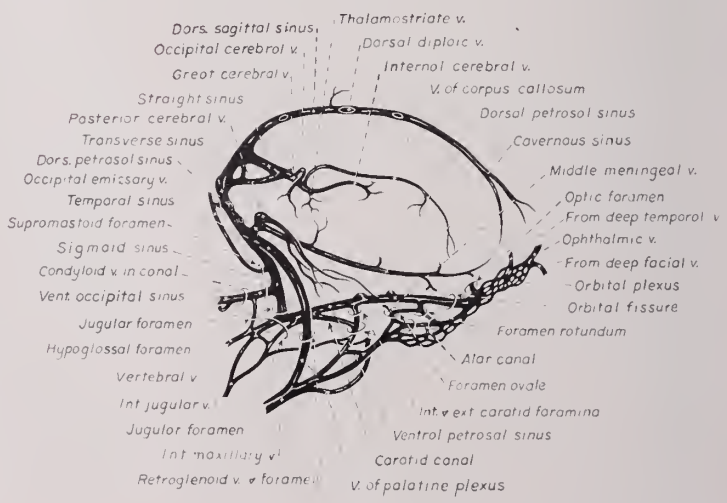

Fig. 2—Semi-diagrammatic representation of cerebral venous drainage, intracranial channels and connections to major effluent veins, is shown. (From Fig. 3., K. R. Reinhard, M. E. Miller and Howard E. Evans, Am. J. Anat., 111:72, used with permission.)

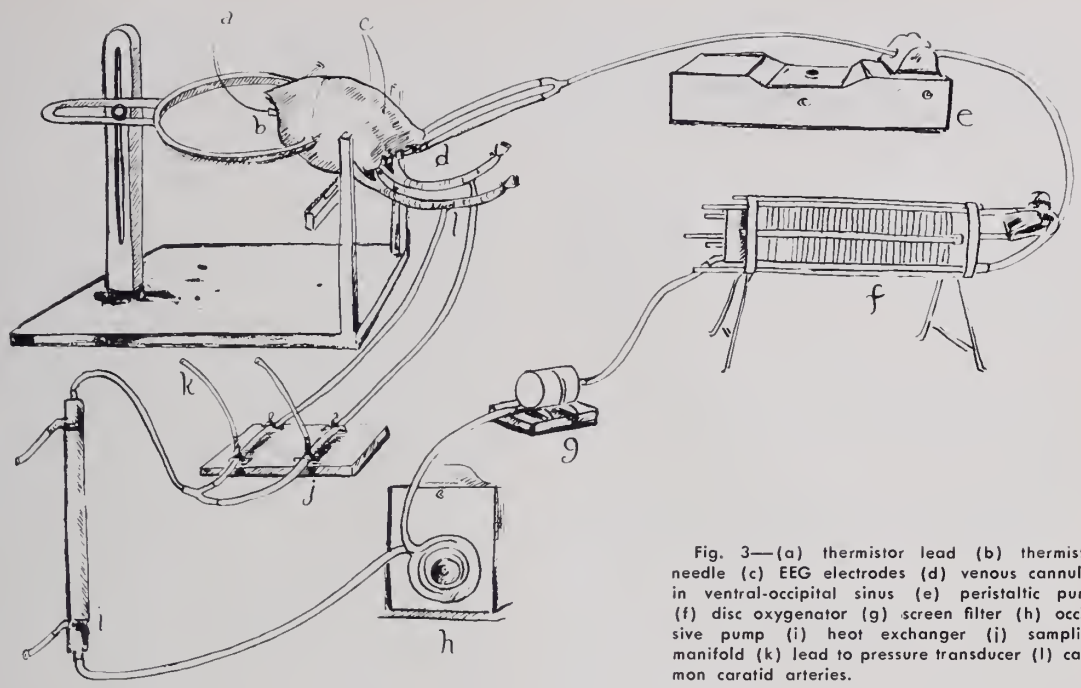

Fig. 3—(a) thermistor lead (b) thermistar needle (c) EEG electrodes (d) venous cannulae in ventral-occipital sinus (e) peristaltic pump (f) disc oxygenator (g) screen filter (h) occlusive pump (i) heot exchanger (j) sampling manifold (k) lead to pressure transducer (l) cammon caratid arteries.

arterial pump. The animal is placed in the prone position. Holes are drilled through the dorsal condyloid fossae into the ventral occipital sinuses; tapered luer connectors are inserted and tubes leading to the venous pump are attached. At this time arterial and venous pumps are started to prevent possible cerebral ischemia during the remainder of the operation.

Complete isolation of the intracranial circulation is completed by severing the vertebral column and spinal cord at C3. The brain is now entirely dependent on pump oxygenator blood supplied via the internal carotids and maxillo-carotid anastomotic arteries (Fig 3). The cranium is left intact because we believe its metabolic activity is low, it provides a firm anchor for EEG leads and it prevents drying of the brain substance. If necessary approximately 60% of the remaining skull can be removed for specialized studies. Perfusion pressures, CSF pressure and electrocortical activity are recorded continuously on a 5-channel polygraph. Arterial and venous samples are drawn through sampling ports for determination of blood pH, glucose and oxygen consumption and the formation of other metabolites.

Glucose consumption is 5.08 mg/minute/100 gm of brain tissue, oxygen consumption is 9.16 ml/min/100 gm of brain and blood lactic acid increases at a rate of 0.60 mg/min/100 gm brain tissue. These data are comparable to those found with man.[11]

EEG activity is evident for 4 to 7 hours after isolation (Fig 4). Electrocortical responses can be evoked by loud noises in the vicinity of the external auditory canal and metrazol seizures can be induced at the conclusion of all experiments. Eventually there is loss of amplitude and slow wave formation in all preparations. It has not been established whether loss of electrocortical activity is due to the absence of essential metabolites or the presence of products of metabolism.

In vivo studies of brain metabolism have been hampered by the inability to limit blood flow to cerebral tissue alone. This preparation is being used as a research tool in the study of cerebral fluid distribution, of nu-

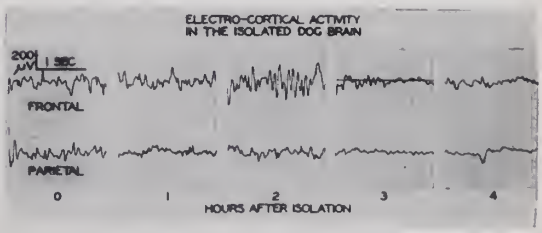

Fig. 4—Electrocartical activity of the dog brain befare and after isolation.

tritional requirements of the brain and of brain metabolism. The isolated brain could be used to study the physiology of cerebral vasculature and the alterations in cerebral metabolism caused by perfusion with chemotherapeutic agents.

Summary. A method for the surgical isolation and perfusion of the dog's brain with proof of viability has been presented. The preparation is considered to be an important research tool.

1300 University Avenue (53706).

ACKNOWLEDGMENT: We wish to thank Mrs. Victor Levin, Mr. Wilbert Herman, and Mr. Alton Mitmoen for their help in this work.

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RUPTURE OF THE RECTUS ABDOMINIS MUSCLE

BACKWINKEL, KLAUS, Department of Surgery, Jackson Clinic, Madison, Wis.: *Archives of Surgery*, 90:35–37 (Jan) 1965.

The author presents a case report of a ruptured rectus abdominis muscle in a 48-year-old woman. He discusses the anatomy and etiology of this condition, evaluates current diagnostic measures and symptomatic clues, and describes the cystogram as a hitherto unreported and valuable procedure in establishing a preoperative diagnosis.

Review of the literature shows that the correct diagnosis is not usually made preoperatively. Only a high index of suspicion and a meticulously elicited history of injury, muscle effort, pregnancy, obesity, or a protracted cough may reward the diagnostician with the correct diagnosis. Most commonly, however, the condition is mistaken for appendicitis, ovarian cyst, ventral hernia, or abdominal tumor.

A variety of diagnostic procedures has been recommended. Most of these tests were either nonapplicable or contraindicated in this case. It occurred to the author that the peculiar anatomy of the rectus sheath with its missing lower posterior leaf might permit a protrusion of the hematoma mass into the pelvis causing extrinsic pressure on the bladder dome that could be demonstrated radiologically. A cystogram taken preoperatively showed marked indentation of the right bladder hemisphere ending almost in a straight sagittal midline corresponding to the confinement of the rectus muscle by the linea alba. A normal contour of the bladder could be demonstrated after evacuation of the rectus hematoma.

The author points out that, since 82.7% of all rectus abdominis hematomas are reported to occur below the navel, the cystogram should be of appreciable diagnostic value in cases in which peritoneal irritation mimics a perplexing variety of pathological conditions.

"OUTSIDE VEIN CUTTER"

Doctors Furman T. Wallace and Richard S. Wilson of Spartanburg, S. C., have devised an instrument for use in varicose vein surgery. It sharply decreases the time needed to remove the main-trunk vessels and reduces the number of incisions.

A cable, acting as a guideline, is inserted into the saphenous vein distally from groin to ankle. Then the extraluminal cutter is introduced over the vein from below upward. Additional incisions are made where the cutter impinges on tortuous segments. The authors point out that it is still necessary to dissect out other tributaries, but the overall anesthesia and operating times are less.

Their paper, "A New External Cutter in Varicose Vein Surgery," was originally published in *The American Surgeon*, October 1957. More recently the device was demonstrated in a film presented at an American College of Surgeons meeting. The motion picture is available from the film library of the American College of Surgeons, 40 East Erie Street, Chicago. The vein cutter is made by Pilling and Sons of Philadelphia.—V. S. FALK, M.D., Edgerton

Orthopedic Problems in Agricultural Trauma

By GEORGE L. LUCAS, M.D. and HERMAN W. WIRKA, M.D., Madison, Wisconsin

■ ONE OF THE LARGEST and most dangerous occupations in America is farming. More fatalities occur in farming than in any other single industry, and the risk of injury to the worker is second only to mining and the construction trade.[1] Accidental deaths in the United States average 100,000 annually; and 4,500 of these, the greatest number of occupational deaths, are among farmers. Moreover, for every fatality there are approximately 100 serious disabling accidents.[2] The time loss to agriculture as the result of farm accidents has been minimally estimated at 20,000,000 working days per year!

In this report the general problem of agricultural trauma mortality and morbidity will be discussed in addition to presentation of case material which illustrates the orthopedists' problems in dealing with such situations.

Everyone is exposed to a variable degree of risk and hazards of his own environment, and in speaking of the labor force, this is called the "occupational hazard." In most industrial situations great strides have been made in eliminating or reducing occupational hazards, largely through regulations which are enforced by employers, unions, and governmental agencies. Such regulatory mechanisms, however, are not operative in the case of the farmer whose safety precautions are self-imposed and who is free to operate with or without them as he chooses. Despite being provided with adequate safety shielding for power take-off shafts, cutting blades, and the like, farmers frequently do not use these important accessories to their equipment.

The farmer must develop a wide variety of skills and become accustomed to considerable changes in his daily work patterns which are engendered by weather and crop conditions. Certain complex machines are used only a few times a year and at a time when the time pressure on the agrarian is great. Hence, fatigue and haste have come to assume an important position in farm accident causation.

Since farming is usually a family occupation, the farmer's child is exposed to risk that the average child does not face. In reviewing examples of farm injuries in 1963, we stressed the importance of parental irresponsibility as a causative factor and pointed out that such accidents are virtually 100 per cent preventable.[3]

Increasing size and decreasing number of farms lead to a decrease in manpower and an increase in utilization of machinery. For example, there was an 84 per cent increase in the use of tractors between 1950 and 1960 on Wisconsin farms.[4] When one considers that nearly 60 per cent of fatal farm accidents involve machinery, the problem of machinery becomes a very consequential one indeed. This has not always been the case and earlier studies have shown falls, animals, and sharp hand tools to have been variously more important causes of accidents.[2,3]

Mortality data for farm accidents are readily available, but morbidity statistics considerably less so. The most recent tabulations of the Wisconsin State Board of Health (1960–1962) indicate that almost 47 per cent of the accidental work fatalities occurred in agriculture. This figure assumes even more significance when one considers that agriculture represented only 11.4 per cent of the total labor force in 1960.[4] In the summer of 1960 a questionnaire-type survey was made in Dane county, Wisconsin, by Cleary et al.[1] (Rural Dane county has 30,180 persons, the second largest farm population in the state.) Their study set the incidence of nonfatal farm accidents at 1 per 10,000 persons per month. There are believed to be almost 9,000 farms in the area which gives an estimated rate of 3.3 accidents per 1,000 farms per month. These figures show again the importance of machinery and falls (nearly 70 per cent of the total number of

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This article is a companion piece to "Farm Accidents Occurring in Children," by the same authors, which appeared in the *Wisconsin Medical Journal* in October 1963.

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accidents) as the prime etiologic factors in nonfatal as well as fatal accidents.

For more precise morbidity figures we refer to a Canadian survey done in Saskatchewan in 1962. The population of this province is 900,000 to 1,000,000 with agricultural occupations being probably somewhat more prevalent than in Wisconsin. The rate for fatal accidents occurring on the farm to farm residents was 9.5 per 100,000 rural population in 1962. This can be reduced to a figure of 0.95 per 10,000 rural population for comparison with the same rate in Wisconsin which is 1.4 per 10,000.[4,5] It should be noted that these figures are exclusive of highway accidents which have been included in the tabulation of Powers[6] and Calandruccio and Powers.[2] In 1962 there were 2,045 patients hospitalized for injuries incurred in farms in Saskatchewan. This is roughly 15 per cent of the total hospitalized accident cases. During the same period 5,163 patients were treated as emergencies in hospitals for farm injuries.

In a previously reported series where the type of injury was indicated, 32 per cent of the injuries resulted in fractures, of which 27.4 per cent were compounded. Lacerations, which frequently involved tendons or nerves and thus required orthopedic care, accounted for another 15 per cent.[2]

Although these figures give some indication of the magnitude of the farm injury problem, the precise causative forces operating remain somewhat ill-defined. As noted, machinery is responsible for a considerable portion of farm accidents. However, the fundamental fault does not lie with machinery or its design, but rather with the operator. As suggested in prior studies,[1-4,6] carelessness, fatigue, and rushing to complete the job appear to be mostly to blame. This contention is difficult to accurately substantiate, but in reviewing the circumstances surrounding the occurrence of a farm accident, one certainly gets this impression. The fact that the hour before noon and the late afternoon, when fatigue and haste are more likely to occur, are the prime times of the day for accidents is strong suggestive evidence in this regard.

The concept of "accident proneness" has been discussed for some years, but the validity of this idea in relation to farm injuries is virtually impossible to assess. However, a recent review by Hirschfeld and Behan[7,8] gives some very convincing examples of how patients may attempt to extricate themselves from a real or imagined dilemma by incurring personal injury. It is not difficult to imagine how a farmer who is struggling to make ends meet for a large family on a marginally productive farm with little opportunity or capacity for recreation might, either consciously or unconsciously, envision a solution through injury.

An attempt was made to determine the frequency of farm accidents requiring hospitalization and orthopedic care in three Madison, Wisconsin, hospitals for the period April 1, 1963, to April 1, 1964. These hospitals, University Hospitals, Madison General, and St. Mary's, with bed capacities of 695, 421, and 289 respectively, handle the majority of trauma cases in the city. Most of the farm accident victims are referred from smaller communities. Unfortunately, accurate figures can not be obtained because present coding does not indicate the mode of injury. However, at Madison General and St. Mary's hospitals the majority of patients who sustained trauma were admitted via the emergency room, so a scan of the emergency room ledger led to several examples of farm injury. At the University Hospitals virtually all orthopedic patients were admitted to one ward and therefore perusal of the ward admission records gave a fairly accurate tally. During the prescribed time, there were 19 patients treated in three hospitals by nine orthopedic surgeons. Despite the seemingly small number of patients treated, it must be realized that these are frequently severely challenging problems of traumatic surgery.

The cases under review are summarized in Table 1.

Closed Fractures. The immediate care of any patient with a fracture is application of a splint. This can be accomplished in a variety of ways and has as its object prevention of further deformity and inhibition of development of shock secondary to painful stimuli. Definitive care can be accomplished in most instances by closed reduction and plaster cast immobilization, although certain fractures such as intertrochanteric fracture of the femur, fracture of the radial head, and some ankle fractures as described may require open reduction and/or internal fixation. Delayed or reconstructive therapy is limited in this group to patients whose general condition immediately following injury does not permit vigorous fracture manage-

TABLE 1—*Summary of Cases Reviewed*

Case	Age and Sex	Type of Accident	Injury	Complicating Factors	Comments
FALLS AND CLOSED FRACTURES					
1	50 M	Fall through roof	Fractured olecranon and intertrochanteric fracture of hip	Decreased motion of elbow	Presently ambulatory. Neufeld nail in proximal femur.
2	58 M	Fell into post hole	Bimalleolar fracture of ankle	No definite treatment 4 months postinjury. Patient treated initially with Ace bandaging!	Ankle arthrodesis required
3	60 M	Fall in barn	Trimalleolar fracture	Carcinoma of lung previously treated.	Presently ambulatory without difficulty
4	66 F	Fall in barnyard	Fracture radial head and ulnar-humeral dislocation.	Carcinoma of breast previously treated.	Good motion following excision of radial head.
5	48 M	Fall from ladder	Metatarsal fracture	--------	Cast immobilization
6	54 M	Fell from nitrogen tank	Avulsion chip fracture of humeral bead and rotator cuff tear	--------	Decreased abduction of humerus presently
7	47 M	Fall from trailer	Fractured radius and carpal navicular	Pain in abdomen leading to sudden collapse on third postoperative day.	Postmortem examination revealed laceration of liver and massive hemoperitoneum
8	57 M	Fall from tree	Disruption of symphysis pubis	Generalized arthritis	Presently ambulatory
MACHINERY INJURY AND/OR OPEN FRACTURE					
9	28 M	Power take-off injury	Compound fracture of left tibia, fracture right scapula	Muscle interposition	Screw fixation of tibia required. Presently ambulatory on crutches.
10	33 M	Fell from tractor	Compound fracture of neck of fifth metacarpal	--------	Satisfactory progress in plaster
11	17 M	Pinned under tractor	Contusion ulnar and radial nerve, laceration elbow, fracture left radius	Radial and ulnar nerve deficit	On exercise program for radial and ulnar nerve palsy
12	47 M	Caught pants leg in power take-off	Hematoma of thigh	Did not seek treatment for 10 days	Hematoma evacuated and wound closed by secondary intention.
13	40 M	Power take-off injury	Severe soft tissue injury and compound fracture of the tibia and fibula	Delayed union	Weight-bearing at present
HAND INJURY					
14	18 M	Blunt trauma to hand from chopping wood	Flexor tendon rupture	Not seen until 3 months postinjury	Improved post-tendon repair
15	53 M	Corn chopper	Avulsion ½ index finger	Pneumothorax following brachial block	Asymptomatic
16	55 M	Cut finger in rod bender while building silo	Amputation of left distal right finger	--------	Asymptomatic
17	30 M	Chain drive of corn stock chopper caught hand	Circumferential lacerations to base of thumb and index finger	Dry gangrene index finger	Amputation of index finger
COMPOUND FRACTURE AND THERMAL INJURY					
18	45 M	Caught in shaft of silo conveyor, exposed to —15° cold for 6 hours	Lacerated hand, compound fracture of humerus. Cold injury.	Renal shut down	Died (see text)
FALLING OBJECT					
19	43 M	Piece of timber fell and struck patient	Contusion and abrasions, multiple, head and shoulder	--------	Asymptomatic

ment. A salvage procedure is indicated in those where satisfactory union does not occur, as in case 2 (Table 1), where lack of a complete initial diagnosis and early treatment precluded adequate healing.

Case 7 is cited as the example of serious complicating factors which may accompany a simple fracture. This 47-year-old white man fell from the back of a trailer and injured his right wrist. General physical examination a short time after the injury was noncontributory except for the deformity and tenderness of the right wrist. X-ray films revealed a fracture of the distal radius and of the carpal navicular. Closed manipulation and casting were performed under general anesthesia. This was repeated the following day because of imperfect reduction. On the third day following injury the patient complained of nausea. Examination of the abdomen revealed no abnormalities, and his symptoms were thought to be secondary to analgesic medication. The following day he had no abdominal complaints and was up and about until 5:30 PM when he suddenly collapsed while walking in the hall. He responded somewhat to resuscitative measures including artificial respiration, oxygen, and

vasopressors for a time but died shortly after a tracheostomy was performed at 8:30 PM.

Autopsy revealed a liver laceration with massive hemoperitoneum and multiple retroperitoneal hematomata. The day following injury his hematocrit reading was 45% and hemoglobin level, 14.9 gm/100 ml.

Machinery Injury and Open Fractures. Although the patient described above was examined for injuries accompanying fracture, his signs and symptoms of intra-abdominal pathosis were so occult that recognition was not accomplished antemortem. This case demonstrates the need for complete examination of the patient who sustains traumatic injury, and this is nowhere more important than in the patient who has incurred sufficient trauma for open fracture to have occurred. The immediate approach to such a patient, therefore, is to determine the presence of accompanying injuries such as airway obstruction, gross hemorrhage, and shock, and to institute the proper measures in addition to splinting of the fracture.

After the patient's general condition is stabilized, primary care can begin with administration of prophylactic therapy for tetanus; either tetanus toxoid, 0.5 ml, if the patient has been previously immunized or tetanus antitoxin after proper skin testing or the more recently available antitoxin prepared from human sera. The value of prophylactic antibiotics in open fractures generally is debatable; because of the gross contamination usually seen in farm wounds, however, antibiotics are usually given.

The patient should be taken to the operating room as soon as possible and copious irrigations of the wounds carried out with saline followed by wide debridement of all devitalized tissues. Fixation of the fracture can then be performed either by insertion of traction wires, plaster casting, or in certain instances such as unstable tibial fractures, metal implants may be necessary. The commonest complication requiring further management with this type injury is infection and delayed or nonunion.

One type of infection to be especially feared is gas gangrene. At least three cases of gas gangrene secondary to compound fracture occurred in this community within the mentioned year. Interestingly, however, these instances were all associated with auto accidents and not farm injuries. Because the treatment of gas gangrene is currently undergoing revision, it is pertinent to discuss it briefly here. Polyvalent antitoxin is no longer indicated prophylactically and is becoming less prominent in the therapy of established infection. The Department of Defense does not utilize this material and various authors have questioned its usefulness.[9-14] Hyperbaric oxygenation has been used recently for gas infection with a reportedly high rate of success,[15] and shows great promise, although still only available in research centers.

At the present time established gas gangrene would appear to require vigorous debridement and/or amputation, high doses of penicillin and tetracycline, supportive treatment with blood and fluids, and especially drenching of the tissues with oxygen under high atmospheric pressure.[15]

Hand Injury. Few organs of the body can be dispensed with less readily than the hand. Unfortunately, the hand is frequently injured in farm accidents and may be totally lost in corn pickers, hay balers, and the like. Emergency treatment of hand injuries requires splintage and control of hemorrhage. Further treatment is directed to prevention of infection and fixation of the fractures. Additionally, the skin coverage may be a problem in hand injuries which may require local flaps, primary pedicle grafts or free skin grafts. Fundamentally, the treatment of hand injury is directed to save as much of the hand as possible and all attempts should be made to avoid sacrifice of any components with the capacity for satisfactory function. Often hand injuries involve compound fractures which are complicated by the fact that the hand will not tolerate prolonged immobilization.

Case 18 is described to illustrate the deadly hazard of working alone with machinery improperly shielded. A 45-year-old white man was filling a silo by himself when he became caught in the rotating shaft of the conveyor at 10 AM. The patient was not found until 4 PM the same day and had lain in the —15° cold unable to extricate himself for six hours. He was taken to the local hospital where intravenous fluids and sedation were given. He was then transferred to University Hospitals where he arrived with a blood pressure of 80/50 mm Hg and demonstrated a severe compound, comminuted fracture of the right humerus and laceration

over the dorsum of the left hand as well as severe abrasions and contusions over the lower extremities.

Warming was instituted with blankets; and blood, fluids, tetanus antitoxin, and chloramphenicol were given before the wounds were cleansed and debrided with local anesthesia in the operating room. A traction wire was placed in the olecranon. The patient had a modest urinary output over the next 12 hours but became markedly oliguric 24 hours following admission. The following day peritoneal dialysis was begun. The patient experienced a rocky course, although his condition was generally somewhat encouraging until 10 days following the injury. At that time he developed high fever and convulsions progressing to coma, and died the following day despite tracheostomy and other resuscitative measures.

Postmortem diagnoses were as follows: (1) multiple traumatic injuries upper and lower extremities with compound fracture right humerus, (2) lower nephron nephrosis with acute renal failure, (3) pseudomonas peritonitis, (4) adynamic ileus, (5) acute gastric dilatation, (6) bilateral atelectasis, and (7) bilateral serofibrinous pleuritis.

Summary. Accidents are responsible for twice as many deaths in persons one to 25 years old as the next two most frequent fatal diseases combined. During the next 20 years of life, accidents are superceded only by cardiac disease as the cause of death.[6] Accidents incurred while at work are responsible for a substantial portion of these deaths, and in this group agricultural mishaps contribute a major portion. The number of agricultural deaths is not only prodigious, but rather than showing a decrease as in some other industrial categories, is actually rising. More importantly, for each agricultural injury resulting in death, there are approximately 100 nonfatal injuries of varying severity. These are responsible for an amount of time lost from work which has been conservatively estimated at 20,000,000 working days per year. The etiologic agents in such accidents excluding motor vehicle accidents on rural highways, are predominately falls and machinery. More fundamentally perhaps, 70 per cent of farm accidents can be ascribed to carelessness, fatigue, and haste; i.e., theoretically preventable.

The concern of the orthopedic surgeon becomes obvious when one notes the nature of the traumatic event and resultant lesion in most farm injuries. It can be seen from this small series of cases that agricultural trauma produces serious musculoskeletal injury. In this report, fundamental principles of surgical treatment, general supportive care, proper splintage, adequate cleansing and debridement of wounds, prevention of infection, and secure fixation of fractures are stressed. Modalities of treatment of such injuries are not likely to improve appreciably in the near future, whereas we can expect some improvement in rural medical facilities. However, until each individual farmer maintains a constant awareness of the danger of his tools and environment and healthy respect for them, farm accidents will continue to occur at a substantial rate.

Conclusion. Farm accidents are a continuing source of injury and death in the United States. The nature of injury is such that orthopedic surgery is frequently required and such cases present the orthopedic surgeon with serious and challenging problems indeed.

1300 University Ave. (53706)

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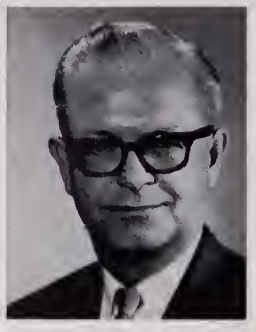
THE PRESIDENT'S PAGE . . .



J. H. HOUGHTON, M.D.
Wisconsin Dells

"Peace on Earth to Men of Good Will"

■ WHAT DOES THIS mean and how does this apply to each one of us? Consider the turmoil in the world—the war in Vietnam, the trouble in Rhodesia, the unrest between the black race and the white race, not to mention the yellow race, the strife between management and labor, the struggle in our country between Government and Medicine. Those on each side of these controversies believe they are in the right—that they are men of "good will." By what yardstick do we judge who and what is right?

There is no one answer to this question. We believe what we believe according to the environment and experience to which we've been exposed. Each one of us believes ardently in the cause he espouses.

For this short period in our year, the Christmas Season, let's forget our differences and look on others as sincere individuals in whatever cause they champion, so we can sincerely say to one another: "Peace On Earth to Men of Good Will."

J. H. Houghton, M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Doctors' Dollars

■ MIXED WITH THE colorful greeting cards and once-a-year letters from old friends comes the spate of charity solicitations to pluck at heart strings tuned to the "Good Will to Men" theme. While many of the causes that make a Christmastime appeal are indeed worthy, doctors should consider carefully their charitable allocations.

As our national affluence grows, the sophistication of fund-raisers improves apace. The flood of unordered merchandise, piteous appeals, coy appeals, subtle appeals and outright demands for a large variety of charities is a tribute to the science and art of professional letter writers. And while many fraudulent charities have been exposed, new and unexpected ones keep cropping up.

One worthy cause that has proved its worth year after year is the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. The cost of raising funds for the Foundation is practically nil, and you can be sure that your entire contribution will be used for the purpose you intend. You can earmark your donation for any use you desire within the Foundation's broad range of activity. And your money supports not only the needy but also the advance of science.

What better charity for a doctor than a doctor's charity?

—D.N.G.

A New Bank

■ THE DEAFNESS RESEARCH Foundation is currently engaged in a program to alert the public to the possibility of correcting hearing disorders through the application of modern research. It points out the vital role of the general practitioner in the victim's decision either to accept deafness as incurable or to seek further examination to determine if the defect can be remedied.

Loss of hearing is too often given scant notice by family doctors unless it is specifically called to their attention by the patient. Many persons who notice a growing deafness immediately resort to technicians who have hearing aids to sell. As a result, the best part of their lives may be spent seriously inconvenienced and economically burdened by hearing aid equipment that may be entirely unnecessary. Even worse, other patients, because of embarrassment or poverty, may endure a deafness that could be cured completely through an available surgical procedure.

Family doctors should be alert to deafness in their patients; they should be sure that sufferers of deafness are examined by qualified otologists to determine the nature and the extent of the impairment.

To advance the scientific investigation of deafness, doctors should urge their patients suffering from deafness to bequeath their temporal bones, containing the inner ear structures, to the Temporal Bone Banks Program for Ear Research. The banks are established by The Deafness Research Foundation in cooperation with the American Academy of Ophthalmology and Otolaryngology. There are 39 banks participating in the program, and they are interested only in the inner ears of persons who have had a serious hearing loss or other types of ear disorder. The bones are carefully studied by scientists to seek clues for the cause of the donor's deafness and to gain information that may help others to hear.

Information booklets and pledge forms may be obtained from the Deafness Research Foundation, 366 Madison Avenue, New York, N.Y. 10017 —D.N.G.

Specialization and the Family Doctor

Dr. George Reader, professor of medicine at Cornell University Medical College, says that "students enter medical school interested in patients and leave it interested in disease . . . and they somehow cease to be humanitarians."

He explains that the modern medical training process apparently turns students against family practice. They feel the practice of medicine is solely to combat serious illness and are distressed at the idea of entering any form of practice in which they would have to deal with "crocks," student slang for patients with generalized complaints for which nothing much can be done.

It is true that specialization has entered the profession, especially in the large population centers, in the last 25 years and to some extent in the Fox Cities area. There have been complaints in recent years that some doctors won't answer a night call and some do so reluctantly. But in this area, these are in the minority.

Many young doctors today are seeking positions in lucrative clinics, the bigger the better, where they are associated with many specialists and can practice medicine in their own time.

Just recently, a young medic came to Appleton and thoroughly explored the possibilities for establishing his practice in the Fox Valley but he could find no clinic large enough to suit him. He now is considering an offer in a clinic in another area where he would be associated with 70 physicians.

Dr. William Stewart, of the U.S. Public Health Service, has charged that "doctors are just not doctoring. In the 1930s a doc was a doc. Today he is a researcher spending half his time in some lab staring into a microscope, or he is an administrator or he is a specialist practicing only a small part of medicine."

Although there are a goodly number of specialists in the Fox Valley, we do not think much of this criticism applies to doctors here. We hope the students who get so interested in disease itself that they cease to be humanitarians will continue to settle in the larger population centers.—Reprinted from the *Appleton Post–Crescent*, Oct. 22, 1965

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Minutes of Council Meeting

MADISON, OCTOBER 8, 1965

1. Call to Order and Roll Call

The meeting was called to order by Vice Chairman Nordby at 3:20 p.m. on Friday, October 8, 1965, at Society headquarters in Madison.

Voting members present were Doctors James, Schulz, Nordby, Davis, Stoops, Carey, Blanchard, Kief, Nadeau, Manz, Chojnacki, W. J. Houghton, Van Hecke, Wright, Curran, J. H. Houghton, and Callan.

Others present were Doctors Bernhart, Stovall, and Lorenz; Messrs. Murphy, Kluwin, and White, consultants; Messrs. Crownhart, Koenig, Ragatz, Reynolds, Waldschmidt, Ryder, Maroney, Brower, W. J. Brown; Mrs. Anderson, Misses Cordts and Pyre.

Guests present representing Student AMA Chapters: Bob Stanhope and Donna Bienlein from Marquette; Kenneth Kloehn, Leigh Iverson, and Joanne Selkurt from the University of Wisconsin.

2. Approval of Minutes

On motion of Doctors James–Blanchard, carried, minutes of the August 1, 1965, meeting were approved.

3. Mental Health—Special Order

A. A. Lorenz, M.D., of Eau Claire, represented the Society on the State Comprehensive Planning Committee for Mental Health and Mental Retardation. He discussed with the Council the report of this committee, entitled "Guidelines for Action," which was to be presented at Wisconsin's first Congress on Mental Health and Retardation at the University of Wisconsin on October 15, 1965. He suggested that Council members study the report and ask the Division on Nervous and Mental Diseases to review it in detail.

4. Report of Finance Committee

Doctor James reported the recommendation of the committee, as reported directly to the House of Delegates, that the 1966 budget be adopted essentially as it was in 1965, recognizing that adjustments may well be required during the year to meet presently unknown demands upon time and dues income.

On motion of Doctors Kief–Schulz, carried, the report was accepted.

5. Report of Planning Committee

Doctor Kief reported the following for action or information:

A. Liaison Between the Council and Society Committees

In October 1964 the Council discussed the proposal that a mechanism be established for chairmen of the numerous committees of the Society to meet with the Council, and the Planning Committee was asked to make a specific recommendation.

The committee considered the number of committees, the organizational structure of committees, and the new practice of Division chairmen having direct access to the Council through the Chairman of the Commission on State Departments rather than having to clear proposals with the entire membership of the Commission.

The committee recommended that a letter be sent to all Society committee chairmen by the Chairman of the Council, inviting them to appear before the Council or its Executive Committee whenever they feel a report or action by the Council is desirable, and that committee chairmen be reminded of their opportunity to appear before the Reference Committees of the House of Delegates.

On motion of Doctors Kief–Nadeau, carried, this recommendation was approved.

B. Area Hospital Planning Committee

The committee reviewed the current situation in various areas around the state, and decided to recommend that a State Medical Society area hospital planning committee as such not be created at this time, but that the Commission on Hospital Relations and Medical Education be asked to develop guidelines for use by the local committees in the field of area hospital planning.

On motion of Doctors Kief–Houghton (J. H.), carried, this recommendation was approved.

C. Annual Meeting Dates and House of Delegates Schedule

(1) The committee reported for information that the feasibility of setting meeting dates and locations for the next five years was discussed and it was concluded that at this time no action be taken. The committee felt it would be wiser in view of all the variables that must be taken into account in planning an annual meeting to have the benefit of the La Crosse meeting experience, and the matter will be reviewed after the 1966 annual meeting.

(2) The committee considered the schedule proposed by Doctor Callan that the annual meeting be so scheduled that the Council and all House of Delegates sessions would be held on Sunday and Monday.

At the present time the House of Delegates sessions and the scientific sessions are purposely interwoven so that delegates will have the opportunity to attend both. The Planning Committee agreed that the present schedule should be maintained to assure maximum attendance by delegates at the scientific sessions and to enable the reference committees to have adequate time to formulate reports.

By way of review, it was pointed out that the Council has taken action on the schedule for the La Crosse meeting, and the House will hold its first session Monday noon, and the second and third sessions the latter part of Tuesday afternoon.

6. Report of Executive Committee

President Houghton or the Secretary reported these several recommendations from meetings of the Executive Committee on August 28 and October 8, with Council action being recorded:

A. National Conference on Rural Health

On motion of Doctors Houghton (J. H.)–James, carried, the Council forwarded to the House a resolution inviting the American Medical Association to hold a National Conference on Rural Health in Milwaukee. (See October 1965 House proceedings and action on Resolution A.)

See Supplement, pp. 481–516, accompanying this issue for Reports and Proceedings of the House of Delegates, Interim Session, October 9, 1965.

B. Historian

On motion of Doctors Houghton–Wright, carried, the Council will proceed with the study and eventual appointment of an historian.

C. Department of Health

On motion of Doctors Houghton–Blanchard, carried, the Council forwarded to the House a resolution for introduction at the AMA Clinical Convention supporting the creation of an independent cabinet level department. (See House proceedings and action on Resolution B.)

D. Code of Ethics

On motion of Doctors Houghton–Schulz, carried, the Council forwarded to the House a resolution urging development of a code of ethics by the federal government for employees involved with the administration of Medicare. (See House proceedings and action on Resolution C.)

E. Bylaw Annotation

On motion of Doctors Houghton–Kief, carried, the Council approved insertion of the following comment following Chapter III, Section 9 of the Bylaws:

"This provision was inserted to assist in providing delegates with advance information of matters coming before the House and to avoid last minute resolutions which have not received study through some appropriate mechanism. Individual councilors, however, are not within the meaning of the term 'constitutional officers' for they are part of a total body—that of the Council—and should submit any request to the Council and not directly to the House."

F. Council Award and Presidential Citation

Council members were asked to submit any nominees they have in mind for these awards in 1966.

G. Division on Nervous and Mental Diseases

The Council was informed that due to the press of other obligations, Doctor Wunsch had resigned as division chairman, and Doctor Lorenz, vice chairman, will serve until Council elections next May.

H. Educational Campaign on Venereal Disease

On motion of Doctors Houghton–Schulz, carried, the Council forwarded to the House a resolution endorsing the campaign of the American Medical Association. (See House proceedings and action on Resolution E.)

I. Hospital Awards

On motion of Doctor Blanchard, variously seconded, the Council approved a citation to four hospitals, to be awarded in 1966, for disaster care provided in an emergency.

J. Utilization Review Requirements of Medicare

On motion of Doctors Houghton (W. J.)–Van Hecke, carried, the Council forwarded to the House a resolution calling upon county medical societies to take the appropriate action in reference to utilization review programs as required by P. L. 89–97. (See House proceedings and action on Resolution D.)

In a related action, and on motion of Doctors Kief–James, carried, the Council instructed the Commission on Medical Care Plans to organize an Advisory Committee on Hospital Utilization Review Committees, such action to be reported to the House.

K. Commendation of AMA Board of Trustees

On motion of Doctors Nadeau-Kief, carried, the Council recorded its commendation of the leadership taken by the AMA Board of Trustees, such action to be reported to the House of Delegates and to the AMA.

L. State Board of Health Advisory Committee

The Society is privileged to submit nominees for a member of the advisory committee provided by the 1965 Hospital Regulation and Approval Act.

Of the nine nominees suggested by the Executive Committee and Council members, the following were chosen by ballot: Drs. W. P. Curran, C. O. Vingom, and George B. Murphy, Jr. The State Board of Health will select one.

M. Community Health Week

On motion of Doctors Blanchard–Chojnacki, carried, the Council transmitted a resolution to the House endorsing Community Health Week being sponsored by the American Medical Association. (See House proceedings, report of Reference Committee on Reports of Officers.)

N. Report of the Secretary

The Secretary reported that with approval of the Executive Committee he would report to the House that in the current study of liability insurance, there be incorporated the possibility of extending coverage for any liability which might be imposed on a member of a utilization review committee.

Another recommendation was the creation of a new state board or commission charged with reviewing legislative requirements or proposals in matters of medical practice, such as compulsory testing of a specific nature. Such a board would be composed of representative physicians who would have the judgment to review such matters, not ordinarily present within the legislature itself.

7. 1966 Annual Meeting in La Crosse

Mr. Ragatz reported enthusiastically on the progress made to date in planning for the La Crosse meeting.

8. Osteopathy

On motion of Doctors Van Hecke–Schulz, carried, the Council directed that county medical societies not having the benefit of legal counsel in matters related to relationships with osteopaths be provided such counsel by the State Medical Society wherever they become an issue.

9. Councilor Resignation

The Secretary announced that he had been informed of the resignation of Howard J. Lee, M.D., as councilor wholly for personal reasons.

On motion of Doctors Chojnacki–Blanchard, carried, Doctor Lee's resignation was accepted.

On motion of Doctors Chojnacki–Van Hecke, carried, W. J. Egan, M.D. was appointed to replace Doctor Lee as councilor, to serve until the next annual meeting.

10. Wisconsin Medical Journal

The Secretary reported for information that the north central states have requested Wisconsin participation in discussing the possibility of a regional medical journal during the North Central Conference, November 6–7.

11. Adjournment

The meeting adjourned at 9:05 p.m.

C. H. Crownhart
Secretary

Approved:
E. J. Nordby, M.D.
Vice-chairman

(Subject to formal approval by the Council)

REPORTS AND PROCEEDINGS OF 1965 INTERIM SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin
OCTOBER 9, 1965

Supplement to WISCONSIN MEDICAL JOURNAL
December 1965

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REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT THE INTERIM SESSION

State Medical Society of Wisconsin October 9, 1965

The Interim Session of the House of Delegates of the State Medical Society of Wisconsin was held at the State Medical Society headquarters in Madison, Wisconsin, October 9, 1965.

Presented below are reports submitted to the House. Following these reports are the Proceedings of the House which include the recommendations of the reference committees and the House actions on these reports.

■ REPORT OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS—OCTOBER 1965

D. E. Dorchester, M.D., Sturgeon Bay, Chairman
R. J. Botham, M.D., Madison, Vice-Chairman
J. E. Martin, Jr., M.D., Delavan
J. S. Devitt, M.D., Milwaukee
Louis Olsman, M.D., Kenosha
C. A. Olson, M.D., Baldwin
C. J. Picard, M.D., Superior
R. G. Hansel, M.D., Baraboo
R. R. Rueckert, M.D., Portage

While the Commission on Public Relations and Communications has not met formally this year, there has been correspondence and activity in carrying out its programs earlier authorized. The Commission is submitting at this session the report of its Committee on Occupational Health and recommends its approval.

The Commission also feels that a summary of continuing activities of the Society, in the field of health education, would be of interest and value to members of the House.

Health Education Program

While statistics are not entirely indicative of the scope and effectiveness of a program, the figures do reflect the volume and variety of services provided by the Society to the people of Wisconsin. Following is a tabulation for the first seven months of 1965:

News Releases	115
Speakers	19
Loan Packets	22
Pamphlets	15,235
Films	7

News Releases issued from the Society Office publicize activities of the Society and interpret its position on various matters. They are sent to newspapers, radio and television stations, and on occasion specially prepared for magazines.

Speakers are provided for statewide and regional meetings; the figure does not include requests for local programs which are traditionally forwarded to the appropriate County Medical Society. Emphasis for the first seven months of 1965 was on quackery and legislation (5 requests each).

Loan Packets are provided to physicians and the general public when information is requested in great depth. Requests during this reporting period covered such topics as fluoridation, health careers, quackery, alcoholism, mental health, the American Medical Association and athletic injuries.

Pamphlets are requested by a variety of people on an almost limitless number of subjects. The Society makes a special effort to solicit requests from 4–H clubs in the state and from young people interested in health careers. The high number of pamphlets distributed in the first seven months of this year reflects a response in the latter category. A total of 12,292 pamphlets on careers in the health field were distributed to students, parents and guidance counselors.

Films provided during the period reflect requests from physician members. While the Society does not maintain a film library, it does have a file of film sources and makes appropriate arrangements for scheduling.

March of Medicine

Worthy of special mention in the Society's public education program is the "March of Medicine" radio program, carried weekly on 54 radio stations and affiliates in Wisconsin. The program reaches an estimated 350,000 persons in Wisconsin each week and provides a service whereby listeners may write in for scripts or request additional information from the Medical Director, H. Kent Tenney, Jr., M.D. In the first seven months this year, Doctor Tenney personally responded to 709 listeners and an additional 750 persons requested copies of scripts.

Conclusion

It is not intended that this report cover the broad scope of Society activities in public health education, but merely inform the House of one portion of that program. For example, the Wisconsin Work Week of Health is one of the outstanding events in this field presented by any medical society in the nation, but is reported to the House separately.

In addition, the Commission continues to look for new and different methods of communicating health information to the public. Its investigations and pilot programs in one of the more promising areas —television—have thus far indicated that the impact on budget and staff of a continuing series of high caliber makes it unfeasible to contemplate such a project at the present time.

While it will continue to explore all avenues of improving the Society's program in the field, the Commission feels that the continuing program outlined in this report represents a substantial contribution to bettering the health of Wisconsin residents.

An informed public not only avoids questionable health practices and practitioners, but is able to make better use of the health services and facilities available to them.

■ REPORT OF THE COMMITTEE ON OCCUPATIONAL HEALTH OF THE COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS —OCTOBER 1965

James M. Wilkie, M.D., Madison, Chairman
R. S. Wright, M.D., Racine
Carl Zenz, M.D., Milwaukee
O. T. Mallery, Jr., M.D., Wausau
Louis Olsman, M.D., Kenosha
D. E. Dorchester, M.D., Sturgeon Bay
Donald M. Ruch, M.D., Milwaukee
J. V. Flannery, M.D., Wausau
Allen G. Brailey, M.D., La Crosse
William W. Ford, M.D., Green Bay

The Committee on Occupational Health has met three times in the past twelve months. It recently increased its membership to ten members to pro-

vide better distribution and representation in areas of experience and geography.

Occupational Health Clinics

For ten years, 1944–1954, the State Medical Society sponsored a series of occupational health clinics in various communities in the state. It is the recommendation of the Committee that these clinics be reactivated, under auspices of the CES Foundation, with the first scheduled for Milwaukee in November of 1966.

It is contemplated that the clinics will be self-supporting and that the Foundation will be reimbursed supporting funds upon completion.

Occupational Health Programs for Hospital Employees

In late 1964, "A General Guide for an Occupational Health Program for Hospital Employees" was published and distributed to chiefs of medical staffs and hospital administrators in the state. This guide was a cooperative effort of the State Board of Health, State Medical Society, Wisconsin Hospital Association and Wisconsin Nurses Association.

The Committee urges individual physicians to provide leadership in adapting the guide to conditions in their local hospitals, and helping to establish such programs.

Future Projects

The Committee is studying the Workmen's Compensation Panel Program to determine if changes are necessary before the panels are next published in 1967. It is also revising the publication "Occupational Health—A Guide for Medical and Nursing Personnel." Also under study is the possibility of providing advisory services to industries interested in establishing occupational health programs.

Reports on these projects will be made at a later date, when the Committee has developed specific recommendations.

■ REPORT OF COMMISSION ON STATE DEPARTMENTS—OCTOBER 1965

T. W. Tormey, Jr., M.D., Madison, Chairman
W. J. Egan, M.D., Milwaukee, Vice-Chairman
A. M. Hutter, M.D., Fond du Lac
H. A. Anderson, M.D., Stevens Point
J. W. Nellen, M.D., Green Bay
John R. Evrard, M.D., Milwaukee
Charles A. Wunsch, M.D., Green Bay
H. W. Carey, M.D., Lancaster
Paul A. Dudenhoefer, M.D., Milwaukee
James L. Weygandt, M.D., Sheboygan Falls
James C. H. Russell, M.D., Fort Atkinson
Meyer S. Fox, M.D., Milwaukee

The Commission on State Departments reported activities and proposed plans for the ensuing year to the House of Delegates during the May, 1965 session but takes this opportunity to report actions taken during the organizational meeting of the Commission held in July and the activities that have received the consideration of the Divisions since the last meeting of the House.

The Commission has met with representatives of the State Board of Health, the State Department of Public Welfare, the State Board of Vocational and Adult Education, the State Motor Vehicle Department and the State Department of Public Instruction to discuss activities and problems with which the Divisions and the representatives of state government will be concerning themselves.

Among these will be recently enacted legislation providing health care for the aged, legislation providing educational opportunities for those from the lower socio-economic groups and federal rehabilitation programs. These and many other government sponsored projects will be main items of concern which will require the advice, the consultation, the guidance and the coordination of the Commission on State Departments.

In reviewing recent activities of specific Divisions, the Commission has approved participation by the Division on Aging in "Focus on the Future" a program being sponsored on October 26 and 27 by the Commission on Aging. The Division on Aging will also continue to review nursing home programs in the state, the classification of nursing homes, and will coordinate the activities in reference to new legislation providing nursing home care. Postgraduate programs being sponsored by the Society on the care of the elderly will also receive the active participation of the members of the Division.

The Division on Rehabilitation reported to the Commission its work with the Department of Vocational and Adult Education in the establishment of the usual, reasonable and customary fee concept. The Division on Handicapped Children reported that it will emphasize congenital anomalies in its meeting considerations.

The Division on Visual and Hearing Defects has reported that it plans to continue its work in the revision of the "Impairment of Vision Guide" and will work with the University of Wisconsin in conducting a training program for hearing tests. The brochure, "Hearing Conservation in Industry" will also be revised and it is planned to send this information to all boards of health and to industrial nurses.

Cooperation and consultation with the Wisconsin State School Health Council and with the Wisconsin Interscholastic Athletic Association have been and continue to be projects of the Division on School Health. For example, the Division has recommended a proposed change in the rule on hernia now being used by WIAA. The "Guide on Athletic Disqualification—Junior and Senior High School Level" which was produced under the direction of the Division of School Health has received a favorable reception from physicians, the national organization of the Interscholastic Athletic Association and from the American Medical Association. Permission has been granted to the Wisconsin Interscholastic Athletic Association to reprint this Guide, and copies have been made available to their national organization. The Division has also made plans to be represented at the Tenth National Conference on Physicians and Schools.

The Division on Maternal and Child Welfare reported at the summer meeting of the Commission on State Departments that since 1958 sixteen interpretive programs on maternal mortality have been held and approximately 3,000 physicians and nurses have attended these programs which deal with actual cases of maternal deaths. The Division has received the approval of the Commission and of the Council to conduct three programs, one in Milwaukee, one in Green Bay and one in Spooner. These programs will associate the problem of infant identification with the studies on maternal mortality, and will be conducted in two sessions, one part dealing with maternal deaths and the other with child identification.

The Division on Nervous and Mental Diseases has planned a program which will deal with "The Problem Child: Medical and Psychological Aspects." Arrangements have also been made for distribution of "Guidelines—A Manual of Hospitalization Pro-

cedures for the Mentally Ill in Wisconsin" to the membership of the Society.

The Commission has received the approval of the Council to begin a study of the proposal to end the services of the Diagnostic Center in Madison. The WISCONSIN STATE JOURNAL (see Exhibit A) carried an article on July 23, 1965, stating that in a report to the 1965 legislature, the Committee to Visit State Institutions had recommended that the Diagnostic Center in Madison should not be continued as a separate operating facility.

The Society, through the Division on Maternal and Child Welfare, actively supported the founding of the Diagnostic Center in 1943–44–45 and the need for this facility as a teaching institution as well as one offering services to the residents of our state will be considered in depth.

This report to the House of Delegates only summarizes the actions considered by the Commission since the last report to the House. The reports submitted in May from the Divisions on Aging, Visual and Hearing Defects, Nervous and Mental Diseases, Maternal and Child Welfare, Chest Diseases, Safe Transportation, School Health and Handicapped Children list in detail activities that are to be considered in the months ahead.

New Division members and representatives of the agencies of state government who were appointed in July and those who continue to serve unexpired appointments all deal with the wide scope of activities being coordinated under the Commission on State Departments.

This coordination of many activities enables the State Medical Society of Wisconsin to speak with one voice, and hence a stronger voice, on a great number of projects which are of vital concern to the health of Wisconsin citizens and to the practice of medicine.

EXHIBIT A

Reprinted From the Wisconsin State Journal, July 23, 1965

Let Diagnostic Center End, Legislative Committee Says

The phasing out of the Wisconsin Diagnostic Center has been recommended by a legislative study committee.

In a report to the 1965 Legislature, the Committee to Visit State Institutions said the diagnostic center at 1552 University ave. should not be continued as a separate operating facility.

The committee, composed of seven legislators, reported that the center is operating considerably below potential patient capacity.

Capacity Reduced

When it opened, it had a capacity of 76 beds. This number has since been reduced to 55.

The center had its highest average daily population in 1959 with 40 patients but this number has declined to an average daily population of 29 in the 1964 fiscal year.

"The committee finds very disquieting the cost to the state of this operation," the committee reported. "Because of the large complement of highly - trained professional persons and the small number of patients, the per capita cost has been extremely high —averaging about $23,000 in fiscal year 1964."

The committee said the center was originally intended to be a receiving station for persons committed to the Department of Public Welfare and these persons were to receive a complete mental and physical examination at the center.

"It was believed that such an examination would assure individual placement in the appropriate departmental facility and would give departmental personnel an opportunity to suggest proper rehabilitation programs," the committee said.

The report said that although the welfare department does refer some cases to the diagnostic center from the sex deviate program and from the field offices of the division for children and youth, the largest number of center patients now comes from juvenile court referrals.

"The committee notes that each state welfare institution has its own medical and psychiatric staff," the report said.

The committee said discontinuing operation of the center would not mean elimination of a needed service to state citizens.

More Community Service

It said there has been a significant development of local mental health services and last year 76 per cent of Wisconsin's population lived in counties with community mental health clinics.

The committee said with only a small addition to the staff, Mendota and Winnebago state hospitals could provide the pre-admission diagnostic procedure for potential mental patients the center now provides.

The committee report said other functions of the diagnostic center could also be obtained at existing facilities.

■ REPORT OF DIVISION ON REHABILITATION OF THE COMMISSION ON STATE DEPARTMENTS—OCTOBER 1965

Paul A. Dudenhoefer, M.D., Milwaukee, Chairman
J. F. McDermott, M.D., Wauwatosa
C. E. Koepp, M.D., Marinette
R. E. Housner, M.D., Richland Center
Louis Kagen, M.D., Milwaukee
R. L. Gilbert, M.D., La Crosse
C. H. Flint, M.D., Minocqua

During late 1964 and the first part of 1965, the Division met with representatives of the Vocational Rehabilitation Division of the State Board of Vocational and Adult Education relative to fees paid to physicians by these two agencies.

Having received prior authorization from the Council in 1963, the SMS Division directed its efforts to establishing the usual, customary and reasonable charge concept as the method for physician reimbursement.

The Division reviewed a "Guide" which lists procedures and which will provide full payment in the majority of cases when the dollar amount indicated is not exceeded. This "Guide" will serve as an audit device against payments. It will enable the Vocational Rehabilitation Division to reimburse physicians usual, customary and reasonable fees in the majority of cases which will be encountered. For those cases in which charges exceed the amounts shown in the "Guide," because of the characteristics of the care rendered in the particular instance, it will require supporting information from the physician and based on that information might result in payment of charges in excess of the amount shown in the "Guide." Upon request these cases will receive preliminary adjudication by the State Medical Society with the final decision being that of the Vocational Rehabilitation Division.

It was emphasized that this is not a "Fee Schedule" and its publication or circulation throughout the state is not authorized. Notification to the physicians in Wisconsin was made by the Vocational Rehabilitation Division on March 22, 1965, at which time the new plan embodying the usual, customary and reasonable charge concept was placed into effect.

As of this date there has been very little difficulty in the administration of this method of reimbursing physicians for professional services. In fact, no case has been referred to the State Medical Society for adjudication.

Our Division was pleased to receive the new *Directory of Rehabilitation Resources in Wisconsin*, a

publication of the Wisconsin Rehabilitation Association and the Vocational Rehabilitation Division.

This directory lists known rehabilitation resources in Wisconsin and is to be made available to physicians upon request, placed in hospital libraries, and given general dissemination where physicians may utilize it.

Vocational Rehabilitation requested the establishment of a Medical Advisory Committee for disability determination which committee may be called upon to act in an advisory capacity. The SMS Division has appointed a subcommittee to act in such capacity.

The Division feels that the general subject of rehabilitation will receive quite an impetus with the advent of the federal programs for care of the aged recently enacted which will go into effect in 1966.

While the Division anticipates no unusual problems in these areas, it stands ready to act as a guiding influence to the various state agencies and others who may seek its advice.

■ REPORT OF COMMISSION ON PUBLIC POLICY—OCTOBER 1965

W. T. Russell, M.D., Sun Pairie, Chairman
C. F. Broderick, M.D., Wisconsin Dells, Vice-Chairman
E. C. Quackenbush, M.D., Hartford
L. W. Schrank, M.D., Waupun
T. E. Henney, M.D., Portage
J. M. Lubitz, M.D., Brookfield
L. J. Kurten, M.D., Racine
G. O. Stubenrauch, M.D., Milwaukee
J. A. Kelble, M.D., Milwaukee
J. L. Teresi, M.D., Brookfield
G. M. Shinners, M.D., Green Bay
W. W. Moir, M.D., Sheboygan
K. L. Siebecker, Jr., M.D., Madison
H. A. Peters, M.D., Madison
J. V. Bolger, Jr., M.D., Waukesha
J. S. Veum, M.D., Appleton
R. L. Gilbert, M.D., La Crosse
J. B. Durst, M.D., La Crosse
P. K. Odland, M.D., Janesville
S. A. Freitag, M.D., Janesville
A. D. Anderson, M.D., Madison
J. H. Houghton, M.D., Wisconsin Dells
F. E. Drew, M.D., Milwaukee

Introduction

Inasmuch as the Wisconsin Legislature recessed on July 30, 1965, and will reconvene early in October, this is necessarily only an interim report. When the Legislature recessed, it had introduced more than 1,800 bills, substitute amendments and joint resolutions. Of this number 178, or about 10 per cent, have been considered by the Commission because they related directly or potentially to the health of Wisconsin people. Final legislative action has been taken on only 42 of these bills to date, leaving 136 bills to be acted upon when the Legislature returns.

The legislative attorneys for the Society prepared a summary of the status on July 30 of each of the bills considered by the Commission and this report incorporates portions of it. A copy of the summary is attached, in the hope that each Delegate will read it.

Not all of the bills reported to the Society call for the same efforts. Bills are classified under one of the following headings: (1) action; (2) watch; and (3) informational. Those in the *informational* category are not closely followed unless a specific request is received from the Society, or a significant amendment is offered.

There are many others on which the Society takes no formal position, but which your legislative representatives *watch* closely for the possibility of the introduction of an amendment having significant public health implications. In this group are such bills as those dealing with: the final tax-budget (903, A.), clean air (365, A.), correction bills of the Revisor of Statutes, and a deficiency appropriation for HAPA (486, S.). In the same category are also various bills defining eligibility for various welfare programs and touching upon the status of the elderly.

The remainder are the so-called *action* bills. These are followed each legislative day and are individually reported on to the Society as amendments are introduced, hearings are scheduled, or committee or floor action occurs. Some of the more representative of the action bills will be summarized in a later section of this report.

Society Support vs. Opposition

Physicians are advised from time to time by legislative bulletin or otherwise of major legislative developments. They are also called on for help when support or opposition of an important bill makes this advisable. It may be of interest to offer an analysis of the number of bills actively supported or opposed during the first seven months of the 1965 session.

To be really meaningful, such an analysis must include not only those bills unconditionally supported or opposed, but those which the Society feels need amendment. Further, certain levels of activity should be recognized. When a bill is to be opposed, generally this means a positive and in some cases, an all out effort to defeat it. In other cases of support in principle, no such all out effort is required.

Statistically, the breakdown is:

(a)	Support (full)	16
(b)	Support (in principle)	8
(c)	Support, with amendments	12
(d)	Oppose, if not amended	5
(e)	Oppose as drafted	7
	Total*	48

*Includes bills relating to public health, exclusive of health insurance.

It is significant that the Commission, in the name of the State Society, supported 36 bills and opposed 12, including the bills supported or opposed with qualifications. This means that 3 bills were supported for each 1 which was opposed. Such a ratio reflects the positive outlook of medicine on legislation. That outlook includes a long tradition in this state of helping make health legislation as good as possible by offering constructive amendments to bills which the Society would not necessarily have introduced, and supporting the improved result.

In terms of legislation, of the 16 bills in group (a), 4 have been enacted and 1 has passed one house; of the 8 in group (b), 2 have been enacted and 1 has passed one house; of the 12 in group (c), 1 has been enacted with amendments approved by the Society, 3 which were not amended were killed, and the others appear likely to pass with needed amendments; of the 5 bills in group (d), 2 have been enacted with Society drafted amendments, 1 has passed one house amended but not yet in line with Society policy; and of the 7 in group (e), 1 was killed, another is considered unlikely to pass, 1 passed one house unamended, and 1 passed one house with a partially crippling amendment.

Many of the bills which the State Medical Society supports are passed quickly and quietly. Bills which the Society opposes are frequently those

which another organization or group favors, and the Society must call for the fullest efforts of its members to insure the effectiveness of its opposition.

In addition, instructions are sometimes requested on bills which have no immediate effect upon public health and the practice of medicine, to permit the Society to oppose these bills should they be amended in a way detrimental to the public health. This makes medicine's position appear to be one of opposition when, in reality, there is no objection to the proposal itself, but only a readiness on the part of the Society to act in the event such bills are used as a vehicle to undermine the public health.

In summary, the overwhelming number of bills in which the Society takes an active interest receive its active support, its support in principle, or, are unopposed by it. For some reason, the Society's opposition seems to attract more attention both among its members and in some areas of the public.

Bills Introduced or Amended; Related Activities

Society representatives drafted and arranged for the introduction of 8 bills in the current session. It offered substitute amendments on several bills and amended 11 others. In addition, physicians were called on several times by legislative committees to furnish scientific explanations and interpretation of the effects of various bills. They did this sometimes through committee appearances, sometimes by memoranda to a committee and upon occasion by letters to an individual legislator.

The Society staff and its legislative counsel were called upon frequently to furnish factual data, legal interpretations, opinions on constitutionality, or otherwise to assist a committee, an analyst for one of the party caucuses, or individual legislators. There were continuing contacts with the Governor's office which conveyed medicine's position where it was invited or needed.

In addition, the Society, through one of its officers, or in the name of this Commission, addressed individually typed letters to one or the other house from time to time on the position of organized medicine on a particular piece of proposed legislation. From day to day the Society and the Chairman of the Commission received analyses of new bills and of important amendments, together with significant floor actions, notices of hearings and similar information.

The Society conducts its legislative program in the philosophy that public health is a basic responsibility of the government to all people and that public health legislation should be considered on factual and scientific levels and not on a basis of personal interest or of party politics. If individuals or groups make health legislation a partisan matter, as sometimes happens, that is their choice, but it is not the choice of organized medicine.

When the large number of health bills is considered, plus the fact that some of them have been considered as often as three times by the Commission or its Executive Committee, and that many hours have been spent by some physicians on just one bill, and many times that by Society staff members and lobbyists, the Commission believes the Delegates will agree that there has been a good deal of sustained effort put into legislative activities during the current session.

Commission Activities

The House may recall that the Commission on Public Policy was substantially enlarged a year ago. Today it has more than 20 members, where it earlier had only 7. The new members have shown great interest in legislation and the Commission, despite its size, appears to be functioning well. The representatives of the specialties add a dimension to the Commission's consideration of the vital subject of health legislation.

The full Commission met following the May session of the House, and the Executive Committee has conferred several times. On occasion conference calls have been arranged with the Executive Committee and sometimes other physicians, where lack of time did not permit the calling of a meeting. Staff and legislative counsel for the Society attended all meetings and were involved in all conference calls.

The Commission also sponsored the Conference on Health Fads and Fallacies. A separate report is being made on that Conference.

Health Bills of Special Interest

The Commission wishes to indicate the scope of the bills it considered by a brief reference to representative categories or to important individual bills. Delegates or other physicians interested in a more thorough study of this point are urged to read the attached status report of July 30.

Health Assistance Payments Act

HAPA, the Wisconsin Kerr–Mills law, was the subject of 13 bills. Three of these were concerned with therapeutic radiology or with the services of physical therapists or optometrists. The Legislature passed a deficiency bill covering utilization during the year ending June 30 in excess of the appropriation. It has also made an appropriation for the fiscal year which began July 1, 1965, but it is significant that this appropriation ends June 30, 1966, instead of covering the biennium as is usual with appropriations. The passage of the Medicare Act by the Congress at the end of July has left the future of HAPA in doubt in Wisconsin.

Battered Children

Five bills have been introduced to extend further the battered child law enacted in the 1963 session of the Legislature. The position of the Society is to consider such reporting to be in the public health interest, but that to promote the reporting of such cases there should be relief from any legal action for such reporting. This is the position that we presented to the Legislature in supporting all five, none of which have been enacted.

Blood and Tissues

The Society supported actively a blood and tissue bill that has been enacted into law. The bill would eliminate legal problems under the new and recently effective Uniform Commercial Code as to warranties of fitness for use in the procurement, processing and distribution of blood and tissues to be used for transfusions and transplants.

Chiropractic

Again, the chiropractors have attempted to obtain the title "Doctor" in its various forms for their use in treating the sick. Similar legislation has been offered in almost all the sessions of the Legislature for the past 20 or more years. Medicine's position is the same as the Wisconsin Supreme Court's, that a chiropractor only wants the title so that he can better attract people. Chiropractic schools are not recognized by associations which accredit colleges and universities, such as the University of Wisconsin. None of the credits given at any chiropractic school is transferrable to our state university. Again, as in the past two sessions of the Legislature, we have lost the issue in the Assembly. The bill, 277, A., is now in the Senate and the membership must continue to keep their State Senators informed of the issue and the position of the Society.

First Aid

The deaths of the Chief Clerk of the Senate and the Chief of the Legislative Reference Library have brought to the attention of the Legislature the need to assess the emergency first aid facilities in the Capitol and the State Office Building. The State Medical Society has offered to cooperate in any way possible and the Dane County Medical Society has appointed a physician to consult with the Department of Administration which is conducting the study.

Another bill which would require any person who offers first aid to have a first aid certificate from the Red Cross or the Bureau of Mines was supported, provided that an amendment was added to exempt physicians. The bill was killed by the Assembly.

Optometry

The Wisconsin Optometric Association has again been active in the Legislature. One bill, 368, A., which would have prevented dispensing opticians from fitting or placing contact lenses to the eye even under the direct supervision of an ophthalmologist has passed the Assembly. However, the amendments have made it so unworkable that even the optometrists appear to be considering a revision in the Senate. We expect that this bill will be active in the fall session and State Senators must learn of the dangers to public health inherent in this legislation from all members of the Society.

Three other bills are pending dealing with the corporate practice of optometry, 369, A., the inclusion of optometrists under the benefits of the Health Assistance Payments Act and, 518, S. authorizing the optometrists to set up a nonprofit program mechanically similar to those of the Blue Plans.

Pharmacy

The State Board of Pharmacy and the Wisconsin Pharmaceutical Association introduced a series of bills dealing with the various aspects of pharmacy and narcotics. The Society has supported almost all of these bills which strengthen the laws in this area. It did not support one measure that would give the board control over physicians in the area of dangerous drugs. However, we have assured the board that if an amendment were placed on the bill assuring the necessary independence of physicians, the bill would be acceptable.

PKU

There are three bills pending which deal with testing for PKU. The State Medical Society has taken the position that reporting of testing to the State Board of Health and of suspected cases of PKU will give statistical and clinical data needed to perfect information in this area. The bills all make testing mandatory and justify this approach on the basis that it is the only way of assuring that the tests will be made. Physicians have explained that organized medicine has handled many other situations, such as the RH factor in the newborn, without legislation and that it should be allowed to do so in this recently developing area.

Reorganization of State Departments

In its original form a bill would have permitted either house of the Legislature to reorganize any State Department, such as the Board of Health or the Board of Medical Examiners, by bringing in a proposed reorganization plan in bill form and filing it. As drafted, the bill would have permitted passage of such reorganization without public hearing and without a vote by either house.

The State Medical Society, in common with other professional groups, opposed the bill in its original form on the basis that this could lead to ill considered and irresponsible action, or just as bad, to the reorganization of an important department by default of legislative interest or knowledge.

A substitute amendment was brought in which met the most substantial of the objections of medicine and the other concerned professions.

Hospital Regulation

A comprehensive hospital licensing and regulation bill was introduced at the request of the Wisconsin Hospital Association, with the support of the State Board of Health. Amendments were offered to safeguard the independent judgement of physicians caring for hospital patients and to minimize the danger of duplication in regulation. The Society will have a representative on the advisory committee which will evaluate or propose regulations to the Board of Health to implement the act.

The amendments requested by the State Medical Society were acceptable to the Board of Health and incorporated into the bill which passed just before adjournment.

Miscellaneous

A number of other bills were either introduced at the request of the State Medical Society, or were supported by it following their introduction. They proposed legislation calling for:

(a) Special licenses for residents in training in this state.

(b) Employment by an island township of a physician so as to assure him a minimum income. It was designed for Washington Island, off Door County, and, as worded, is limited to islands.

(c) Increasing the number of licenses which the Board of Medical Examiners is authorized to issue to foreign trained physicians.

(d) An increase in the per diem of the Board of Basic Sciences; and an increase in the number of subjects covered by the examination so as to reflect scientific advances of the past 40 years and make reciprocity with other states easier.

(e) Expanding by 25 per cent the admissions to the University of Wisconsin Medical School.

In addition, there were a number of bills relating to mental health and to various welfare categories which were followed by the Society.

Summary

While final action has been taken on slightly under one-fourth of the bills which the Commission has been following, all bills have been analyzed and reported to this Commission; public hearings have been held on all but a small number. Thus, much more work has been done than would appear from the unexplained statistics that final action has been taken on only a minority. On balance, it is believed that health legislation has fared well in this session. Much activity lies ahead, but it will be concentrated at the action point and it is likely that a substantial number of bills will be recommended for indefinite postponement (killing). Some new health legislation may be introduced this fall, but it is likely that the number will be small. Your Commission expresses the confidence that the Legislature will continue the long-established tradition of dealing intelligently and fairly with health legis-

lation. A few exceptions may occur, but these usually represent heavy lobbying by forces that have only one or two bills of interest to them and which sometimes successfully confuse the real health issues which their bills present.

For the very reason that health legislation plays an increasingly significant role in our Society, organized medicine has the responsibility of intensifying rather than diminishing its efforts in that area.

OFFICE MEMORANDUM FROM MURPHY, STOLPER & DESMOND

Re: Legislative Report as of July 30, 1965 (Date of Recess to October 4, 1965)

ACTION

Bill	Relating to:	Status
JR 53, S.	Emergency first aid in capitol	Adopted 7/7/65
42, S.	Interstate Compact on mental health	In Senate Public Welfare—Hearing held 6/29/65
90, S.	25 to 50 Foreign physician licenses	On Assembly Table (Note: Assembly bill 124 same)
92, S.	PKU mandatory testing	On Senate Calendar—Adoption of Sub. Amendent 1, S. recommended
186, S.	Basic Science Board	Referred to Senate Joint Finance on 3/18/65
203, S.	Basic Science Subjects	In Senate Education—Hearing held 3/10/65
212, S.	Eligibility and Benefits under HAPA	Referred to Senate Joint Finance on 4/14/65
218, S.	Blood or tissue transfer services not sale of blood tissue	Passed Senate and Assembly. Pending before Governor
320, S.	Battered child reporting	Passed Senate—In Assembly Judiciary
368, S.	Pharmacy permit for hospital drug rooms	In Senate Public Welfare—Hearing held 5/11/65
371, S.	Fraud or deceit in connection with dangerous drugs	On Senate Calendar—Passage recommended
373, S.	Possession of dangerous drugs	On Senate Calendar—Passage recommended
375, S.	Nonprofit insurance plans under Ins. Comm'r.	Indefinitely postponed 6/16/65
509, S.	Exempt one foreign physician from licensing requirements	Chapter 106, Laws of 1965
518, S.	Nonprofit plans for optometrists	In Senate Public Welfare
526, S.	Radiology under HAPA	Referred to Senate Joint Finance on 7/15/65
541, S.	Expansion of U. W. Medical School	Referred to Senate Joint Finance on 7/15/65
27, A.	Repeal of 5% deductible in Kerr-Mills	In Assembly Joint Finance
65, A.	Chemical tests for intoxication	Indefinitely postponed 4/1/65
81, A.	Liability for intoxication blood withdrawal	Indefinitely postponed 3/26/65
87, A.	Methods and technicians on blood tests	Indefinitely postponed 3/26/65
97, A.	Implied consent for intoxication tests	In Assembly Judiciary—No action pending
124, A.	25 to 50 foreign physician licenses	Chapter 9, Laws of 1965
185, A.	Battered child—county welfare	On Assembly Calendar
199, A.	Battered child—State Department of Public Welfare	In Assembly Judiciary
216, A.	Seat Belts in all seats	In Assembly Highways
247, A.	Drivers license test for aged—Optometrists certify	Returned to Author 3/11/65
277, A.	Use of title doctor by chiropractors	Passed Assembly—In Senate Public Welfare—Hearing held 6/15/65
314, A.	Reports of battered children to county welfare department	In Assembly Judiciary
368, A.	Dispensing opticians and contact lens	Passed Assembly; In Senate Public Welfare; Hearing held 7/27/65
369, A.	Corporate practice of optometry	In Assembly Commerce and Manufactures—Hearing held 4/22/65
370, A.	Battered child syndrome	In Assembly Public Welfare—Hearing held 3/16/65
409, A.	Reorganization of boards by order	Passed Assembly and Senate—Pending before Governor
422, A.	PKU tests	Assembly passed Sub. Amendment 1, A.—On Senate Calendar
442, A.	Medical payments in old age assistance	In Assembly Joint Finance
592, A.	Barring subrogation clauses under accident and sickness insurance	In Assembly Insurance and Banking—Hearing held 4/21/65
619, A.	Inclusion of physical therapist services under HAPA	Passed Assembly—Pending on Assembly message in Senate
752, A.	Nonprofit insurance plans statutes	In Assembly Insurance and Banking
762, A.	PKU testing	In Assembly Public Welfare—Hearing held 5/18/65
768, A.	Admission and retention of mental patients	On Assembly Calendar—Indefinite postponement recommended
772, A.	Pay for patients	In Assembly Judiciary—Hearing held 6/15/65
776, A.	Commitments to private facilities	On Assembly Calendar—Indefinite postponement recommended
793, A.	Safety harness in automobiles	On Assembly Calendar—Indefinite postponement recommended
800, A.	Hospital regulations and approval act	Passed Assembly and Senate—Pending before Governor
847, A.	Resident doctors employed by town boards	Passed Assembly and Senate—Pending before Governor
869, A.	Emergency first aid cards	On Assembly Calendar—Indefinite postponement recommended
882, A.	Optometrists in HAPA	On Assembly Calendar—Passage recommended
886, A.	Two medical student loan funds	In Assembly Joint Finance
912, A.	Residence licenses	In Assembly Public Welfare—Hearing held 7/20/65
975, A.	Abortions	In Assembly Public Welfare

WATCH

JR 9, S.	Asking Congress to expand Kerr-Mills	Enrolled 5/5/65
JR 34, S.	Creating a special committee to study mental illness	In Senate Joint Finance
12, S.	Payment in kind for ADC	Chapter 157, Laws of 1965
16, S.	Mental Health Advisory Committee and Alcoholism	Chapter 137, Laws of 1965
23, S.	Blue Cross Amendments	Chapter 17, Laws of 1965
27, S.	Inadmissibility of recorded phone conversations	In Assembly Judiciary—Hearing held 7/20/65
77, S.	Milwaukee Teachers H and A insurance premiums deduction	Chapter 37, Laws of 1965
99, S.	Governor budget bill	Assembly nonconcurred in 6/10/65

Bill	Relating to:	Status
111, S.	Revisors bill	Passed Senate and Assembly—Pending before Governor
127, S.	Establish Commission on Juvenile delinquency	In Senate Judiciary—Hearing held 3 10 65
156, S.	Educational expenses income tax deduction	In Senate Joint Finance
161, S.	Basic Health Insurance only for state	In Senate Joint Finance
188, S.	Retired State Teachers Insurance deductions	Passed Senate, in Assembly Insurance and Banking
201, S.	Schools for nursing	Chapter 97, Laws of 1965
208, S.	Repeal of HAPA lien section	In Senate Joint Finance—No action pending
234, S.	Vacancies for mentally deficient persons	Indefinitely postponed 4 22 65
239, S.	Amount of liability for patients at state colonies, etc.	Passed Senate, In Assembly Public Welfare since 7 21 65
240, S.	Commitment of defendants for mental observation	Passed Senate—Placed on Assemhly table 6 1 65
241, S.	Fees for examining physicians	Passed Senate, On Assembly Calendar
272, S.	Governor's tax bill	In Senate Joint Finance—no action pending
281, S.	Contruction of mental retardation facilities and mental health centers	Chapter 176, Laws of 1965
317, S.	Commitment of the mentally infirm	In Senate Public Welfare—Hearing held 6 22 65
369, S.	Regulation of drugs under the Dept. of Agriculture	In Senate Puhlic Welfare—Hearing held 5 11 65
370, S.	FDA powers for pharmacy board	In Senate Public Welfare—Hearing held 5 11 65
372, S.	Exempt narcotic preparations	Passed Senate—In Assembly Public Welfare
486, S.	Additional funds for HAPA	Passed Senate and Assembly—Pending before Governor
489, S.	Insurer rehabilitation	Passed Senate—On Assembly Calendar
499, S.	Suspension of committed incompetents' drivers license	In Senate Highways
JR 53, A.	An interim study of procedures in commitments to mental institutions	In Assembly Joint Finance—No action pending
13, A.	Labeling dangerous drugs	Indefinitely postponed 4 22 65
26, A.	Aids to brain injured children	In Assembly Joint Finance
31, A.	Employment of women and minors	Passed both Assembly and Senate—Pending hefore Governor
75, A.	Repeal of HAPA recovery provision	Passed Assembly—In Senate Public Welfare—No hearing
76, A.	Repeal of HAPA recovery provision	Passed Assembly—In Senate Puhlic Welfare—No hearing
88, A.	Loans for Student R. N.'s	In Assembly Joint Finance
123, A.	Registration lists of physicians	Passed Assembly—Pending on Assembly message in Senate
142, A.	Construction program for U. of W. hospitals	In Assembly Joint Finance—No action pending
152, A.	Tax exemption for incorporated historical societies	Returned to Author 4 6 65
158, A.	Aid to students for courses not offered at U of W	Passed Assembly and Senate—Pending before Governor
187, A.	Insanity as a cause for divorce	On Assembly Calendar
188, A.	65 and disahled medical expenses deduction	Returned to Authors 7 28 65
193, A.	Commitment and release for trial of mental cases	Chapter 132, Laws of 1965
222, A.	Definition of income for HAPA and tax relief	Indefinitely postponed 5 13 65
265, A.	Blood type and diabetic on drivers license	Indefinitely postponed 4 14 65
312, A.	Local health departments	Indefinitely postponed 6 18 65
331, A.	Extend unemployment compensation coverage	Indefinitely postponed 6 28 65
334, A.	Sterilization of defectives	Passed Assembly—Pending on Assemhly message in Senate
357, A.	Scholarsnips for nursing educators	In Assembly Joint Finance
365, A.	Wisconsin clean air act	In Assembly Public Welfare—Hearing 3 16 65
432, A.	Recovery of benefits paid under HAPA	Indefinitely postponed 4 27 65
439, A.	Medical payments for the relative with whom a dependent child is living	Passed Assembly—Pending on Assembly message in Senate
521, A.	Scholarships for nursing students	In Assembly Joint Finance
548, A.	Admission, retention and discharge of mental patients	Indefinitely postponed 6 23 65
562, A.	Workshop for blind employees eligible for state insurance	On Assembly Calendar
606, A.	Requiring seat helt installation on school huses	On Assembly Calendar
691, A.	Insurance agents' licenses	In Assembly Insurance and Banking—Hearing held 6 2 65
698, A.	Bar reduction of benefits when other insurance	On Assembly Calendar
701, A.	Visual acuity for hunting licenses	In Assembly Conservation—Hearing held 5 5 65
754, A.	Statutory accident and sickness policy	In Assembly Insurance and Banking—Hearing held 6 23 65
769, A.	Rights of mentally ill patients	In Assembly Judiciary—Hearing held 6 15 65
770, A.	Transfer and discharge of patients	In Assembly Judiciary—Hearing held 6 15 65
771, A.	Outpatient care of mentally ill	In Assembly Judiciary—Hearing held 6 15 65
775, A.	Detention of inebriates and drug addicts	On Assembly Calendar
777, A.	Return of patients	On Assembly Calendar
807, A.	Income exemption for mentally deficient child	In Assembly Taxation—Hearing held 6 15 65
852, A.	Discrimination	Passed Assembly—Pending on Assembly message in Senate
898, A.	Little Hoover Commission	On Assembly Calendar
903, A.	Budget-Tax Bill	Chapter 163, Laws of 1965
934, A.	Parental responsihility for emotionally disturbed children	In Assembly Public Welfare
960, A.	$40 deductible for HAPA	In Assembly Public Welfare

INFORMATION

JR 43, S.	An interim study of the children's code	No reportable action
JR 45, S.	A study of the children's code	No reportable action
33, S.	Daylight saving	Chapter 6, Laws of 1965
63, S.	Compensation of coroners	Chapter 87, Laws of 1965
69, S.	Compulsory retirement	No reportable action
78, S.	Exempt elderly housing from real property tax	Indefinitely postponed 4 22 65
89, S.	Prohibit sale of cigarettes to persons under 16	No reportable action
91, S.	Unemployment compensation reserve transfer	Chapter 1, Laws of 1965
125, S.	Board of Nursing amendments	Passed Senate—3 18 65

Bill	Relating to:	Status
146, S.	Unemployment compensation committee bill	Chapter 10, Laws of 1965
175, S.	Transfer of appropriations in the P/W Department	Chapter 40, Laws of 1965
176, S.	Revealing secret processes or formulas	No reportable action
197, S.	Minimum wages and overtime	No reportable action
200, S.	Special programming for crippled children	Passed Senate—In Assembly
213, S.	Elimination of maximum amount for aid to the blind	No reportable action
214, S.	Elimination of maximum amount of old age assistance	No reportable action
215, S.	Elimination of maximum amount for aid to the disabled	No reportable action
228, S.	Out-of-state travel for the blind	No reportable action
235, S.	Discharge of patients from county mental hospitals	Passed Senate—4/22/65
236, S.	Return of mental patients	Passed Senate 4/22/65
243, S.	Loans to student nurses	Chapter 98, Laws of 1965
245, S.	Creation of a Wis. Correctional Reception and Treatment Center	No reportable action
249, S.	Workmen's Compensation	Chapter 166, Laws of 1965
279, S.	Wis. Hospital Survey and Construction Act	Chapter 169, Laws of 1965
280, S.	Composition of the advisory committee on nursing home licensing and regulation	Chapter 168, Laws of 1965
314, S.	Pharmacy internship commission at request of Wis. Pharmaceutical Assn.	Passed Senate and Assembly 7/27/65
350, S.	Employees of the county departments of P/W	No reportable action
440, S.	Create insurance agent board	No reportable action
505, S.	State credit for public health dispensaries	Chapter 160, Laws of 1965
543, S.	Reimbursement of Oconto Memorial Hospital action	No reportable action
7, A.	Daylight saving	Returned to author 3/23/65
61, A.	Affiliated Historical Societies	Chapter 31, Laws of 1965
98, A.	Education assistance authority	No reportable action
132, A.	Wage discrimination on account of sex	No reportable action
170, A.	Minimum wages and overtime	Passed Assembly 7/26/65
239, A.	Certification of migrant labor camps	Passed Assembly and Senate
242, A.	Medical expense deduction for aged	No reportable action
244, A.	Abolish maximum for old age assistance	No reportable action
359, A.	State aid to tuberculosis sanatoriums	No reportable action
413, A.	Creation of the Wis. Equal Opportunity Commission	No reportable action
433, A.	Establishing a maximum age for disabled aid	Passed Assembly 7/28/65
445, A.	Payment of medical aid	No reportable action
448, A.	Abolishing the maximum limitations on various grants of aid	No reportable action
449, A.	Hours of labor for women	Returned to Authors 5/12/65
492, A.	Exemption of property used for medical research from general property tax	No reportable action
529, A.	Voluntary admission of resident minors to mental institutions	Indefinitely postponed 7/29/65
530, A.	Discharge of patients from county mental institutions	Passed Assembly on 5/11/65
547, A.	Creating a Wis. correctional reception and treatment center	No reportable action
571, A.	State relief dependent's payments for emergency care by physicians	Indefinitely postponed 6/28/65
599, A.	Removal of the maximum limitation on grants of aid to the blind and permanently disabled	No reportable action
600, A.	Removal of maximum on grants of aid to the blind, OAA and permanently disabled persons	No reportable action
648, A.	Eligibility for aid to dependent children	No reportable action
687, A.	Capital of stock insurance company	No reportable action
688, A.	Incomplete organization of insurance companies	No reportable action
689, A.	Continuity of insurance companies	Passed Assembly 7/27/65
690, A.	Investment assets of domestic insurance company	Passed Assembly 6/29/65
759, A.	Tuition at University and State colleges	No reportable action
861, A.	Community mental health clinics	No reportable action
972, A.	Noxious Weeds	No reportable action

SUPPLEMENTARY REPORT OF THE COMMISSION ON PUBLIC POLICY

WISCONSIN CONFERENCE ON HEALTH FADS AND FALLACIES, Green Bay, April 8, 1965

BACKGROUND: In its continuing effort to combat fads and fallacies in the health field and to improve standards of public health care in Wisconsin, the State Medical Society, in 1963, held the first Wisconsin Conference on Health Fads and Fallacies. Its success resulted in the House of Delegates directing that similar events be held in 1964 and again in 1965. The conferences have been under direction of the Commission on Public Policy.

In initiating the 1965 conference, the House of Delegates specified that it be held in the Fox River Valley area. (The first conference was in Madison and the second at Port Edwards.)

The Commission on Public Policy, acting on this mandate, planned a one-day conference in Green Bay with J. A. Killins, M.D., of that community as Conference Chairman. For maximum impact, the conference was scheduled on Thursday, April 8, with a Pre-Conference Banquet set for Wednesday evening, April 7, to provide for an interchange of information between physicians, speakers and state and community leaders.

PROGRAM DEVELOPMENT: It was concluded that topics on the one-day program should concentrate on major problems in the state. With this in mind, speakers were obtained on the subjects of fads and fallacies in cancer, arthritis, and nutrition; health frauds affecting older citizens; science vs. chiro-

practic; questionable health advertising; and consumer protection. A presentation was also planned on "krebiozen," but had to be canceled when federal court action on this subject opened three days prior to the conference.

PROMOTION: Brochures publicizing the conference were mailed to approximately 12,000 persons in the state. This included some 3,000 opinion leaders, members of the State Medical Society and its Woman's Auxiliary, and representatives of especially interested organizations such as The Arthritis Foundation of Wisconsin and the Wisconsin Division, American Cancer Society. In addition 10,000 inexpensive "flyers" were distributed through physicians offices, hospitals and pharmacies in the Green Bay area. General publicity includes newspapers, radio, television and special publications of groups particularly interested in the topic.

ATTENDANCE: An estimated 225 persons attended the conference, which met expectations, and 36 attended the Pre-Conference Banquet, which was less than anticipated.

While registration information is not complete on all participants, it does represent a sufficiently high percentage for analysis:

ATTENDANCE

Registration by Profession or Occupation

Educational Institutions (Teachers and Students)	55
Public Health (State, County and City)	23
Voluntary Health Organizations	17
Business and Industry	11
Woman's Auxiliary	11
Physicians	8
Farm Organizations	6
Clergy	5
Hospitals	4
Governmental Officials	2
Not Specified	73
Total	225

Registration by Geographical Location

Green Bay	106
Northeast Wisconsin	51
North Central Wisconsin	5
Southeast Wisconsin	9
South Central Wisconsin	7
Southwest Wisconsin	2
Not Specified	45
Total	225

CONFERENCE ON HEALTH FADS AND FALLACIES

Green Bay, Wisconsin, April 8, 1965

PROGRAM

Moderator: J. A. Killins, M.D.
Member, Commission on Public Policy
State Medical Society of Wisconsin
Green Bay, Wisconsin

8:30 a.m. **REGISTRATION**

9:30 a.m. **WELCOME**
W. P. Curran, M.D.
President, State Medical Society of Wisconsin
Antigo, Wisconsin

9:45 a.m. **UNPROVEN CANCER "CURES" COST LIVES**
Francis J. Wilcox
Chairman, Board of Directors
American Cancer Society, Inc.
Eau Claire, Wisconsin

10:05 a.m. **THEY PREY ON PAIN**
John B. Torinus
Vice President and Director
The Arthritis Foundation of Wisconsin
Appleton, Wisconsin

10:25 a.m. **QUESTIONS AND ANSWERS**

10:35 a.m. **BREAK**

10:50 a.m. **NUTRITION NONSENSE**
Miss Joan Reid
Cooperative Extension Nutrition Specialist
Department of Foods and Nutrition
School of Home Economics
University of Wisconsin
Madison, Wisconsin

11:10 a.m. **CONGRESSIONAL INTEREST IN FRAUDS AFFECTING THE OLDER CITIZEN**
John Guy Miller
Minority Staff Director
Special Committee on Aging
United States Senate
Washington, D.C.

11:50 a.m. **QUESTIONS AND ANSWERS**

12:00 noon **LUNCHEON**

Moderator: C. F. Broderick, M.D.
Member, Commission on Public Policy
State Medical Society of Wisconsin
Wisconsin Dells, Wisconsin

1:15 p.m. **THE KREBIOZEN STORY**
H. Doyl Taylor
Director, Department of Investigation
American Medical Association
Chicago, Illinois

1:45 p.m. **SCIENCE VS. CHIROPRACTIC**
Robert G. Zach, M.D.
Chairman, Commission on Public Policy
State Medical Society of Wisconsin
Monroe, Wisconsin

2:15 p.m. **QUESTIONS AND ANSWERS**

2:30 p.m. **BREAK**

2:45 p.m. **CAN YOU TRUST HEALTH ADVERTISING?**
Glenn R. Knotts
Director, Office of Advertising Evaluation
American Medical Association
Chicago, Illinois

3:15 p.m. **WHY THE CONSUMER NEEDS PROTECTION**
John Guill, Jr.
Director, Chicago District Office
Food and Drug Administration
Department of Health, Education and Welfare
Chicago, Illinois

3:45 p.m. **QUESTIONS AND ANSWERS**

4:00 p.m. **ADJOURNMENT**

EVALUATION: Some general conclusions can be drawn from impressions, data compiled in registration, and examination of publicity generated by the conference:

General

a. Excellent program speakers provided timely, comprehensive information on specific "problem areas" deemed to be most significant in Wisconsin.
b. Cooperation of physicians in the area and the Woman's Auxiliary not only proved helpful in staging the conference, but provided a direct relationship of local medical organizations as sponsors of the conference through their state society.
c. Viewing the cumulative effect of the three conferences, they have had a significant effect on concern over health fads and fallacies in Wisconsin.

Immediate Impact

a. Mailings prior to the conference informed thousands of opinion leaders in the state of the Society's concern in this area.
b. Advance publicity was most effective in the Green Bay area, but also generated interest in other areas of the state.
c. Both major wire services carried reports of the conference to all radio and television stations and daily newspapers in the state.

Long Range Effect

a. A majority of the estimated 225 persons attending represented positions or organizations providing for communication of information to many additional people.
b. Educators in the audience provide a continuing benefit for students entering training for careers in health.
c. Students attending will be better prepared to communicate information to people they come in contact with when they enter the health occupations they have selected.
d. Cumulative effect of the three conferences has had a noticeable impact on the Society's public information program on "quackery" as evidenced by increased requests for literature, films, exhibits and physician speakers on the subject.

Implications

a. Advance notice was sent to all legislators, to public health officials and to state governmental officials, informing them of the Society's concern and program topics.
b. Of particular significance was extensive press coverage of the presentation on "Science vs. Chiropractic" by Robert G. Zach, M.D.

RECOMMENDATIONS:

1. The three conferences have generated an interest and "climate" in the state beneficial to the Society's continuing program against health fads and fallacies. The Commission recommends that it investigate the feasibility of conducting a conference in Milwaukee with the assistance and cooperation of the Milwaukee County Medical Society.
2. The Commission on Public Policy also recommends increased activity, under direction of the Commission on Public Relations and Communications, to further encourage requests from the general public for physician speakers, films, pamphlets and exhibits on the subject.
3. Efforts would continue, under direction of the Commission on Public Policy, to inform legislators on matters relating to health fads and fallacies.

■ REPORT OF COMMISSION ON MEDICAL CARE PLANS—OCTOBER 1965

E. M. Dessloch, M.D., Prairie du Chien, Chairman
Robert Krohn, M.D., Black River Falls, Vice-Chairman
R. S. Baldwin, M.D., Marshfield
Charles Benkendorf, M.D., Green Bay
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D., Milton
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
D. A. Jeffries, M.D., Shawano
P. B. Mason, M.D., Sheboygan
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
J. T. Sprague, M.D., Madison
A. H. Stahmer, M.D., Wausau
F. H. Wolf, M.D., La Crosse
J. H. Houghton, M.D., Wisconsin Dells, President
F. E. Drew, M.D., Milwaukee, President-elect

The following report to the House of Delegates includes financial and operating highlights for the six months ended June 30, 1965.

Premium income for the first six months of 1965 totaled $8,679,256, an increase of $1,266,104 (17.1%) over the same period of 1964. Monthly premiums are approximately $200,000 ahead of the 1964 level.

The premium advances attained thus far and the outlook for the balance of 1965 indicate that the budget objective of $17,300,000 will be reached.

Almost a quarter million (247,356) contracts are currently in force, an increase of 20,782 over June 30, 1964. The gain over last year is distributed as follows:

Surgical–Medical	6,351
Hospital	6,167
Major Medical	8,264

Claims incurred by subscribers during the first six months of 1965 amounted to 91 cents of each premium dollar. Utilization of the earned premium dollar during a corresponding period last year equaled 95 cents.

The number of claims paid has continued to increase.

1961	120,751
1962	135,890
1963	165,025
1964	191,386

During the first six months of 1965, 106,274 claims have been paid, a dramatic increase when compared with 1961.

Operating Expense

Operating costs during the first six months totaled $810,411. $807,377 was expended in 1964 for the corresponding period.

Through June, operating expenses represented 9.34% of premium income, and it appears they will remain within the 10% goal established in the 1965 budget.

Investment

Efforts are constantly being extended to improve investment yield and to maximize the productive investment of available resources. These efforts brought investment income of $120,959 during the six months ended June 30, 1965, an increase of 10.2% over last year.

Reserves

The first six months of each year historically produce heavy utilization. Operational "break even" during this period is accepted as unlikely. The first half of 1965 produced a modest addition to reserves of $51,048, and the year-end will doubtless show an acceptable addition to reserves.

Century Plan

A series of bulletins designed to keep Century Plan subscribers correctly informed regarding Medicare has been developed. Century Plan benefits are being redesigned to complement Medicare coverage. WPS has concluded that a bold, imaginative benefit structure is a necessity to maintain leadership in this field.

Promotion

1965 advertising has been designed to convey to the public the role played by the family physician with regard to WPS insurance.

The ad series visually features the WPS–physician relationship. This important relationship continues to provide the guidance that enabled WPS to pioneer the "customary, usual and reasonable" fee concept for a realistic premium.

In recent months, WPS has utilized television advertising via channels in Milwaukee and Madison. WPS plans to continue advertising in all communities through all media.

Radiology

In May the Wisconsin Radiological Society adopted a resolution providing in substance that after January 1, 1966, radiologists will bill for their services independently and not through hospital mechanisms.

The State Medical Society is on record as supporting in principle the position of the radiologists.

Subsequent to the May resolution, a meeting was held with accident and health companies which write hospitalization and surgical-medical insurance in Wisconsin, at which time the Radiological Society's position was explained.

The ultimate impact on WPS programs is unknown. When insurance carriers are billed directly for these services, WPS will find a way to accommodate such billings.

Veterans Administration

The existing Veterans Administration agreement was to terminate June 30, 1965. However, at that time the Commission on Medical Care Plans authorized the signing of an agreement to continue the contract between the State Medical Society and the Veterans Administration through June 1966. The Commission has informed the Veterans Administration that if the agreement is to continue beyond that time, the payment of benefits to physicians for the care of veterans with a service-connected disability should be on a "customary, usual and reasonable" charge basis. It appears at present that this approach might be found acceptable to the Veterans Administration.

New Department Added

While we desire to operate efficiently and within the budget, this has not been and will not be accomplished through sacrificing or restricting service to subscribers. To assure prompt, effective service a Subscriber Service Department has been established. This unit is charged with the single responsibility of answering inquiries regarding coverage, claims, premium and other questions that may concern a WPS subscriber.

Prior to the establishment of this department, inquiries were referred to the specific department or departments which assume ultimate responsibility for implementing processing action. Attempting to merge the handling of individual subscriber problems within departments geared for processing mass work flow cannot be done with the dispatch to which subscribers are entitled. To date, significant improvement in inquiry response time has been accomplished by this new department.

New District Office

Improved service to present and prospective subscribers is one of WPS's primary and continuing goals.

A new district office has been established in Wausau. This brings the direct supervision of the field force under four district managers: Wausau, Milwaukee, Madison and Green Bay.

Giving managers smaller territories and fewer men to supervise has brought them closer to the needs of our subscribers. It is anticipated that increased new business and retention of existing contracts will result.

Test of Performance Survey

The National Association of Blue Shield Plans conducted a survey to determine what portion of total medical expenses was paid by individual Blue Plans. In almost all categories of care WPS paid a higher portion of the patient's total medical costs than the average of all plans tested. Obviously, this is due primarily to the WPS Special Service concept of paying physicians' usual and customary charges.

Conclusion

The suggestions and support of the medical profession in Wisconsin continue to assist WPS's progress toward providing realistic health insurance to Wisconsin residents. This guidance, the product development, sales initiative, and capable management continue to permit the attainment of established goals.

WISCONSIN PHYSICIANS SERVICE
OPERATING HIGHLIGHTS
Year-to-Date July 31

	1965	1964
Contracts in Force	248,433	229,449
Number of Claims Paid	125,075	113,216
Premium Income	$10,163,817	$ 8,694,609
Investment Income	142,551	127,427
Total Income	$10,306,368	$ 8,822,036
Claims Incurred	$ 9,214,970	$ 8,157,116

CONDENSED BALANCE SHEET—JULY 31, 1965

WHAT WE OWN:	
Cash	$ 806,870
Receivables	655,569
Securities—Lower of Book or Market	6,627,868
Fixed Assets—Net	170,856
All Other Assets	102,527
TOTAL PROPERTIES	$ 8,363,690
WHAT WE OWE:	
Accounts Payable	$ 47,256
For Unreported and Unpaid Claims	3,610,089
Unearned Premium	1,890,349
All Other Liabilities	25,141
TOTAL OBLIGATIONS	$ 5,572,835
TOTAL RESERVES	$ 2,790,855

WISCONSIN PHYSICIANS SERVICE

CONDENSED STATEMENT OF INCOME AND EXPENSE

	7 Months Ending 7-31-65	% of Prem.	Calendar Year 1964	% of Prem.
Earned Premium	$10,163,817	100.00	$15,358,519	100.00
Agents' Commissions	45,331	.45	80,437	.52
Benefits Incurred	9,214,970	90.66	13,795,996	89.83
Available for Operations and Reserves	$ 903,516	8.89	$ 1,482,086	9.65
Operating Expense	942,812	9.28	1,629,335	10.61
Net Operating Income or (Loss)	(39,296)	(.39)	147,249	(.96)
Investment and Other Income—Net	142,551	1.40	220,071	1.43
Added to Reserves	$ 103,255	1.01	$ 72,822	.47

ANALYSIS OF PREMIUMS AND BENEFITS

	Earned Premium Income	Benefits Incurred	Benefits Incurred as % of Income
Seven Months Ending July 31, 1965			
Surgical-Medical	$ 5,413,210	$ 4,909,716	90.70
Hospital	4,750,607	4,305,254	90.63
Total	$10,163,817	$ 9,214,970	90.66
Calendar Year 1964			
Surgical-Medical	$ 8,208,653	$ 7,404,420	90.20
Hospital	7,149,866	6,391,576	89.39
Total	$15,358,519	$13,795,996	89.83

■ REPORT OF THE COUNCIL—OCTOBER 1965

James C. Fox, M.D., La Crosse, Chairman

The Council met shortly after adjournment of the House of Delegates in May and acted upon a few substantive matters as well as presenting to the new officers and councilors the organization details and operations of the Society. It met again the last weekend in July in addition to meeting with the trustees of the CES Foundation. A meeting is scheduled for Friday, October 8, and there will be matters to report to the House as a result of that meeting.

Since the special session of the AMA House of Delegates on October 2–3 has been announced, it is anticipated that when the Wisconsin House meets on October 9 complete details of the special session will be available. Consequently, as Chairman of the Council I do not feel it necessary in this report to discuss Medicare and the DeBakey medical complex bill.

As to the first, the news release authorized by the Council, copy of which was sent to all members of the Society, was printed virtually in its entirety in over 50 newspapers in Wisconsin. There was commendatory editorial comment and the announcement received wide publicity through radio and TV media as well.

The Council considered the DeBakey proposal in its broad aspect and referred the matter to the Commission on Hospital Relations and Medical Education. The Executive Committee and the Commission met in joint session with Dean Eichman of the University of Wisconsin Medical School, Doctor Hirschboeck, Vice President, and Acting Dean Kerrigan of Marquette. Further meetings of the Commission will be held as this subject is studied out in its rather complex detail and substantial effect on the public health. However, there doubtless will be developments in the House of Delegates of the American Medical Association, either in its special session in October or its regular interim session in late November, and these will be reported to the House as they become available.

In its meeting following the annual session, the Council approved in principle a resolution just adopted by the Wisconsin Radiological Society, and to refresh the memories of delegates and alternates, it read as follows:

WHEREAS, It is a long established principle of American Medicine that good patient care requires that each physician has a direct responsibility to every patient whom he undertakes to diagnose or treat, and that such responsibility cannot be delegated, and

WHEREAS, The practice of radiology is recognized as an integral part of medical practice both by the State Medical Society of Wisconsin and the American Medical Association, and

WHEREAS, The code of ethics of the Wisconsin Radiological Society, Section 7, Article 6, states that "members shall not divide, rebate, or remit fees for medical services in radiology," and

WHEREAS, Present percentage agreements between radiologist and hospitals are undesirable because they tend to establish an employer-employee relationship contrary to the intent of Chapter 484, Laws of Wisconsin, 1959, they tend to extend the liability of the hospital to cover the professional activities of the radiologist, and they create the impression that professional fees for radiologists are part of hospital costs, thus subjecting the hospitals to unjust criticism, now therefore be it

Resolved, That the Wisconsin Radiological Society holds that radiologists should bill fees for their professional services to the patients to whom they supply these services, and that charges for technical services connected with radiology should be billed by the institution, group, or individual providing such technical services, and be it further

Resolved, That all insurance carriers operating in the State of Wisconsin be informed of the intention of the members of this society to bill patients for professional services beginning January 1, 1966, so that such carriers can arrange to provide appropriate coverage for their policyholders if they so desire, and be it further

Resolved, That the Council of the Wisconsin State Medical Society be requested to advise the Wisconsin Hospital Association that contractual agreements between hospitals and radiologists should be revised to conform with the principles stated herein.

The Society provided its facilities for a meeting called in July by the radiologist with representatives of the health insurance industry to explain this action so that the companies might take the appropriate steps to accommodate the change in billing procedures for their policyholders.

The action was also discussed with officers of the Wisconsin Hospital Association, which has taken the position that this is a matter which can be resolved only at the local level by the hospital, its board of trustees, its medical staff, and the specialist concerned.

Program planning for the 1966 Wisconsin Work Week of Health is under way, and an especially attractive one is anticipated for the 125th Anniversary Year. Mark well the dates of February 14–18, 1966.

The Council has had under consideration and now has determined to proceed with the organization of an association of the professions in Wisconsin such as that existing in Michigan and some other states. The American Medical Association this June encouraged state and county medical societies to participate in the formation of such associations "to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit."

The Council has also been concerned with state legislation, which is fully reported by the Commission on Public Policy.

The Councilors and Officers are members of the board of trustees of the CES Foundation, which also numbers a trustee elected by each county medical society, and seven nonmedical individuals who are:

Hon. Oscar Rennebohm, Madison
Hon. A. Matt Werner, Sheboygan
Mr. Warren E. Clark, Milwaukee
Mr. E. E. Bryant, Stoughton
Mr. Robert B. Murphy, Madison
Mr. Stephen E. Gavin, Jr., Madison
Mr. Earl R. Thayer, Waterloo

The first time that an annual meeting of the trustees has been on an occasion unassociated with the annual meeting of the Society was in Madison on July 31. The agenda occupied a long afternoon, and while in part a review and a report on activities, also included future projects.

After the meeting there was a general expression of satisfaction on the part of many Councilors and Officers, and optimism concerning future programs of the CES Foundation. As noted above, two individuals long connected with interests of the medical profession have been added to the board in the persons of Stephen E. Gavin, Jr., whose father was a prominent physician nationally and in Wisconsin, and who serves as executive manager of the Wisconsin Chapter, Associated General Contractors, Inc. The second is Earl R. Thayer, one-time assistant secretary of the State Medical Society whose interest in the socio-economic and historical affairs of the Society continues unabated.

The voluntary dues proved sufficient, but barely so, to permit the employment of a full-time director and a secretarial assistant. Norman J. Salt, formerly office services manager for the Society, has accepted the position of director.

It is hoped that 1966 will see an increase in the number of contributors on a voluntary basis. These contributions are to a charitable organization, and as such are tax deductible.

The Chairman of the Council feels that substantial headway is being made in planning the 1966 meeting. The Executive Committee and the Council have reviewed the work of the Commission on Scientific Medicine and believe the program will be outstanding and will be a pacesetter for such other meetings as may be located outside of Milwaukee in the future. The House of Delegates is urged to lend its individual and collective strength in encouraging attendance at the La Crosse meeting, as it seems apparent that other communities are rapidly reaching the point where their facilities will be sufficient to handle the state meeting in the near future.

This is scanty information as the Chairman feels that future details will be quite extensive.

In conclusion, the Chairman would like to pay special tribute to Doctors John M. Bell, Eli M. Dessloch, Ralph C. Frank, and Robert W. Mason for their years of dedicated service on the Council. Many have served with distinction and have left this service with no particular mention being made, but it is not often that we lose four members in one year.

SUPPLEMENTARY REPORT OF THE COUNCIL

E. J. Nordby, M.D., Vice-Chairman

This supplementary report will be presented without unnecessary frills and is strictly for the purpose of introducing recommendations for action by this House or informing it of actions taken by the Council yesterday.

Several Resolutions are recommended by the Council for action by the House. I will not take the time now to read them in their entirety, but they will be distributed to you and we expect that you will give particularly careful consideration to those timely and important issues relating to federal legislation.

Resolution A recommends support of the invitation for a National Rural Health Conference in Milwaukee.

Resolution B urges separation of all federal health activities from the present Department of Health, Education and Welfare, and establishing a separate cabinet post.

Resolution C proposes a means to assure respect on the part of government employees administering Medicare for the confidential nature of physician-patient relationship and medical records.

Resolution D, also relating to Medicare, informs county societies of action required by public law 89–97 in the establishment of utilization review committees.

On this related subject, the Council took the following action:

The Commission on Medical Care Plans has been instructed by the Council to organize an Advisory Committee on Hospital Utilization Review Committees with duties as follows:

1. To provide a ready and centralized channel of information in this State as between such committees existing in Wisconsin hospitals.
2. To provide consulting advice to any such committee asking questions or submitting problems.
3. To be informed as to legal responsibilities of local committee members.
4. To provide prompt reporting of developments nationally.
5. And in other ways to be helpful to the physicians composing such committees for the more than 200 hospitals in Wisconsin.

In reporting this action to the House, the Council wishes to emphasize that this is a separate, although somewhat related, activity from that called for by Resolution D, which stems directly from P.L. 89–97 and its imposition of initial responsibility upon local medical societies.

This assignment to CMCP is one of a specialized nature to provide, among other things, technical assistance to physicians serving on hospital utilization review committees and to coordinate these activities at the State level.

Another resolution transmitted to the House for action relates to the educational campaign which has recently been launched by the American Medical Association to eradicate venereal disease. This is Resolution E.

November 7–13, 1965, has been declared "Community Health Week" by the American Medical Association, and some 50 national health associations have joined in this effort. In cooperation with this public service program, with the theme of "Teaming Up For Better Health," the Council offers the following resolution:

Resolved, That the State Medical Society of Wisconsin endorses the observance of Community Health Week by the American Medical Association (November 7–13, 1965) and encourages the active participation of component societies in their respective communities.

The Council has considered at length the matter of maintaining and recording the history of the Society and has taken action to create the position of historian which it will fill at a later date.

The Council was informed of the resignation as councilor of Howard J. Lee, M.D., of Milwaukee, for personal reasons; and on motion of Doctors Chojnacki–Van Hecke, announces the interim appointment of W. J. Egan, M.D., of Milwaukee, to serve until the next Annual Meeting in May of 1966, pursuant to provisions of the Constitution and Bylaws.

Finally, the Council has followed closely developments since July 30 when Medicare became law by virtue of the signature of President Johnson. It recognizes the swift development of procedures and problems by virtue of this unprecedented law in the country. It commends the staff and the delegates of Wisconsin to the meetings of the House of Delegates of the AMA for their earnest and diligent efforts in following these developments, and it commends as well the Board of Trustees of the AMA for their unquestioned loyalty to the interest of public welfare in working as rapidly and as efficiently as possible under trying circumstances.

In conclusion, Mr. Speaker, I would point out personally, as vice-chairman of the Council, that 1965 has been historic in many respects, and among others, it being the first year in which the House of Delegates of the AMA has met twice in special session, these sessions marking the fourth and fifth time in the history of the association.

(The following omission from the supplementary report of the Council as read to the House was presented to the reference committee by Doctor Nordby.)

The House of Delegates has received the budget as recommended by the Finance Committee, which is essentially that of 1965, and which contemplates no increase in dues. It is submitted in full recognition that 1966 may bring unanticipated developments, as occurred this year, which could require postponement of some normal activities. The Council records its agreement with the recommendation of the Finance Committee as reported directly to the House so that it would have advance information as a basis for the establishment of dues.

RESOLUTION A

WHEREAS, The American Medical Association has provided fine leadership and positive action in developing programs and public consciousness of rural health problems; and

WHEREAS, Part of this has been in providing an annual conference in such various areas of the country as will attract the best means of public information; and

WHEREAS, Such a conference was last held in Wisconsin in 1954; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin invite the American Medical Association to conduct such a conference in Milwaukee at the earliest possible date.

RESOLUTION B

WHEREAS, The art and science of medicine is charged with the total and final responsibility for the care of all patients; and

WHEREAS, American medicine has in the past recognized this responsibility and has constantly given the citizens of this country the highest standard of care available; and

WHEREAS, Medicare and other legislation are not welfare, but health legislation, and health is of the greatest personal concern to the citizens of this country; and

WHEREAS, The American Medical Association has by past action resolved that a separate cabinet post be created to administer government sponsored health programs; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin urges the American Medical Association to reaffirm the actual necessity of the creation of a separate cabinet post which shall have complete responsibility for all health activities of the government of the United States of America, and that this cabinet post be headed by a Secretary of Health who shall be a properly qualified Doctor of Medicine; and be it further

Resolved, That this resolution be transmitted to all constituent medical societies of the American Medical Association.

RESOLUTION C

WHEREAS, The enactment of Public Law 89–97 by the 89th Congress on July 30, 1965, will make it necessary for governmental agencies to maintain and have access to continuous health records for each recipient of health benefits; and

WHEREAS, These medical records will include information of a private nature concerning care received from all sources, referrals made, clinical findings reported, and treatment programs recommended; and

WHEREAS, The physician-patient relationship and the confidentiality of medical records has long been a recognized ethical, legal, and moral principle of our society, and the assurance of privacy has become an important element in the practice of medicine; therefore be it

Resolved, That the State Medical Society of Wisconsin be on record that appropriate steps should be taken by the government of these United States to promulgate special ethical conduct for government employees which will protect the patient, assure that the physician-patient relationship is not destroyed and that the confidentiality of medical records is guaranteed; and be it further

Resolved, That this resolution be transmitted to the Wisconsin Congressional delegation and others of prominent influence.

RESOLUTION D

WHEREAS, The State Medical Society of Wisconsin has stated its cooperation in the administration of Public Law 89–97 (Medicare), a copy of that statement being attached; and

WHEREAS, Medicare requires that all "providers of services" (hospitals, including psychiatric and tuberculosis, and extended care facilities) must meet a number of requirements in order to receive payment for services rendered to eligible beneficiaries, and these requirements include a utilization review plan which, among other responsibilities, must serve to (1) assure the medical necessity of services rendered, and (2) promote the most efficient use of available facilities; and

WHEREAS, The law provides that such review be made by ". . . a group outside the institution which is . . . established by the local medical society and some or all of the hospitals and extended care facilities in the locality . . . " for those facilities which do not have their own utilization review plans; therefore be it

Resolved, That the State Medical Society of Wisconsin ask that all of its component medical societies take immediate steps to create, where necessary, and to implement in all cases appropriate programs of utilization review to serve all hospitals and extended care facilities in their respective jurisdictions to the extent that such hospitals and extended care facilities do not have their own duly established programs; and be it further

Resolved, That the State Medical Society pledges its assistance to component societies in fulfilling the requirements of the law and its implementation in the public interest; and be it finally

Resolved, That copies of this resolution be provided all interested parties, including hospital organizations, national organizations, governmental agencies, and other associations of professions.

Statement of the State Medical Society of Wisconsin on Public Law 89–97 Authorized by the Council and Officers on August 1, 1965, and Released August 5, 1965

Medicare has now become the law of the land through the democratic processes of our country, processes of which we may all be proud.

During debates upon the measure, the medical profession voiced its opposition, its reasons for that opposition, and presented alternative proposals. That is a fundamental privilege of the democratic process, a privilege which all citizens must cherish and protect.

But now that Medicare is law, the State Medical Society of Wisconsin, through its members, will provide full measure of constructive leadership in its administration. Where we find improvement necessary, we will speak up. Where deficiencies become obvious, we will not hesitate to point them out. And where the law is effective, we will express our opinion on that as well.

Since this law is now a fact, it will require the kind of leadership that the medical profession, and only the medical profession, can provide. We will provide it.

Nothing less than that could we do in good faith to our patients and in satisfaction of our professional and civic conscience.

RESOLUTION E

WHEREAS, The incidence of venereal disease has almost trebled in the United States during the past five years; and

WHEREAS, The American Medical Association in cooperation with the National Education Association has launched a comprehensive educational campaign on this subject; and

WHEREAS, The Wisconsin State Board of Health is actively engaged in this area of infectious disease; therefore be it

Resolved, That the State Medical Society of Wisconsin endorses the efforts of the American Medical Association in its publicity campaign aimed at the eradication of venereal disease, and pledges its active support to the Wisconsin State Board of Health in its program of public education and reporting of this disease.

■ INFORMATIONAL REPORT OF THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION—OCTOBER 1965

Tht Board of Trustees of the CES Foundation held its Tenth Annual Meeting on July 31, 1965 in Madison. The Board would like to point out that the Foundation filed an informational report at the May, 1965 meeting of the House of Delegates and this report has been designed to inform the Delegates in detail of projects briefly described in May and those activities reviewed and future projects considered in July.

In the July meeting of the Board of Trustees a detailed consideration of educational programs of the Foundation was held. Major educational programs of the State Medical Society, other than the Annual Meeting are specifically identified with the CES Foundation. For the past four years the Speakers Service to County Medical Societies and to Councilor District meetings has been made a function of the Foundation. This service has received generous financial assistance from Merck Sharp & Dohme, the State Board of Health, Wisconsin Division of the American Cancer Society and the Wisconsin Heart Association.

The CES Foundation for the past several years has also contributed to the Milwaukee County Medical Society's scientific institute and the Board agreed that this yearly program should be supported on a continuing basis.

A new Speakers Directory has been compiled under the auspices of the Foundation and lists the programs available. County Medical Societies can obtain the Directory by writing: CHARITABLE, EDUCATIONAL and SCIENTIFIC FOUNDATION of the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

In addition to the Speakers Service, for the past two years a series of one-day teaching programs for physicians has been developed cooperatively with the University of Wisconsin Medical School. These programs in 1964–1965 attracted over 300 physicians, and were self-financing through registration fees.

During the coming year a coordinated series of meetings on "Care of the Elderly Patient" will be presented. Sponsorship of these programs through the Foundation will be supported by Merck Sharp & Dohme.

During the past year, four half hour TV programs, in the areas of "Iron Deficiency Anemia," "Diagnostic Feature of Rheumatoid Arthritis," "Deafness in Early Childhood," and "Acute Renal Failure" were produced. The Board has directed that these four TV tape presentations be made into 16 mm film so that they will be available to all physicians of the state.

Future planning in the area of scientific teaching through the Foundation calls for the continuation of the In-Depth programs at the University of Wisconsin. Also tentative plans have been made for a series of Maternal and Newborn Conferences in Milwaukee, Green Bay and Spooner provided by the Division on Maternal and Child Welfare; and

a psychiatric program in Eau Claire which will be the function of the Division on Nervous and Mental Diseases.

In the area of student loans the Foundation now has approximately $114,000 on loan to medical students. Health career loan funds which are available from "Sabin On Sunday" clinics are made available to medical, dental, nursing and pharmaceutical students who are from the county which donated the funds.

The form used for student loans (Exhibit A) and a sample agreement between a County Medical Society and the CES Foundation (Exhibit B) are being included in this report to enable Delegates to have background information on the administration of student loans so that they may encourage the donation of more funds and can be of assistance to students in their areas who plan to embark upon a medical career. Additional funds are necessary because the number of applicants is fast reaching the point where funds will not be available for all who need them.

The Museum of Medical Progress and Stovall Hall of Health is in the process of operating its fifth exhibit season. Attendance has been higher than ever before and the new season runs from April 15 to October 31.

The Board of Trustees reviewed the operational procedures of the Museum of Medical Progress and Stovall Hall of Health and has recommended that the Executive Committee of the Board of Trustees review attendance charges made at the Prairie du Chien cite. It is felt that the present charge may be too excessive in some instances and perhaps results in the lessening of interest of some individuals who would learn important lessons in health education once they toured the facilities. The Executive Committee is to report its findings on this situation at the next meeting of the Board of Trustees.

Included with this report (copies are available on request to the Society office) is a feature article from the September 5 Picture Magazine of the Minneapolis Tribune which shows the many aspects of the Museum and does a commendable job in outlining the aims and objectives of the Foundation in sponsoring the Museum of Medical Progress and Stovall Hall of Health.

The Board of Trustees considered donations to the Foundation and a table attached (Exhibit C) lists contributions by

(1) Members of County Medical Societies (voluntary billing approved by the House of Delegates)
(2) Additional contributions other than those associated with the voluntary contributions
(3) Donations by County Medical Societies and other organizations

Problems of increasing donations to sponsor activities in the areas of scientific teaching, public health education and student loans were dealt with by the Board in detail and it needs to be emphasized that additional voluntary donations must be forthcoming if the Foundation is to continue to be effective in the above mentioned areas.

The Board of Trustees elected W. D. Stovall, M.D., Madison, President; A. J. McCarey, M.D., Green Bay, Vice-President; Elizabeth Comstock, M.D., Arcadia, Honorary Vice-President; and Gordon J. Schulz, M.D., Union Grove, Treasurer, to guide the many activities which range from loans to medical students, postgraduate teaching programs, scientific research activities, special conferences on maternal mortality, infant care, mental health, medical aspects of sports and aging, collections of medical artifacts, and other memorabilia, hobbies for health, collections, assistance to colleagues in need to memorial lectures and donations.

EXHIBIT A

APPLICATION FOR A STUDENT LOAN

Date_____

To the Board of Trustees of the CES Foundation:
Application is hereby made for a loan in the following health field:
Medicine____ Pharmacy____ Dentistry____ Nursing____
Other_____
Name_____ Phone_____
Present Address_____
Home address, if not present address_____
Permanent address_____ Phone_____
If Wisconsin, in what county are you a bona fide resident*?_____
Name of person who always knows your address_____
Address of this person_____ Relationship_____
Date of birth_____ Place of birth_____
Age____ Marital Status_____ Number children____
Name of parent or guardian_____ Relationship_____
Address of this person_____ Phone_____
Occupation of parent or guardian_____
Do you intend to take specialty training or postgraduate education after completion of formal requirements for licensure or certification?_____
Where do you intend to practice?_____
Please give two personal references_____

*See details in attached addendum.

ACADEMIC STATUS

From what high school did you graduate?_____ Year_____
What college, university or nursing school are you now attending?_____ Class_____
If not now enrolled, please indicate date of acceptance____
What other colleges or universities have you attended?_____
When do you expect to receive your degree or diploma?____
When do you expect to complete your internship? (Medicine and Pharmacy only)_____

To the Applicant: The Student Loan Account of this Foundation is the recipient of donations on a continuing basis from individual physicians, many medical organizations including county medical societies and specialty groups, and from interested non-medical groups and persons.

The Trustees have received funds as memorial gifts and from numerous other sources. One of the outstanding of these has been a bequest contained in the will of Mrs. Reginald H. Jackson, Madison, in memory of her husband, who was president of the State Medical Society of Wisconsin in 1933. Another bequest was that of Florence Duckering, M.D., Sheboygan, who died in 1961. Others include the following county medical societies:_____

If your application is approved, and you receive a loan from one of these accounts, remember that when it is repaid it will again be put to use helping some now unknown student who needs the same kind of assistance you received.

FINANCIAL STATUS

Have you ever received a scholarship?_____ If so, please give details_____
Have you borrowed money for any other sources?_____
If so, give details_____
How much is still owing (if any) and when is it due?____
What financial assistance are you now receiving (e.g., from parents, savings, etc.)?_____
Do you have a part time job?_____ If so, who is your employer?_____
How many hours a week do you work at this job?_____
Pay per hour_____
Names of previous employers_____
How much money do you wish to borrow?_____
What portion of your education would such a loan cover?_____
(Number of semesters)

How soon after graduation, or internship in the case of medical and pharmacy students, would you expect to be able to repay this loan?_____

MISCELLANEOUS INFORMATION

Do you have relatives in the practice of medicine, dentistry, nursing or pharmacy? If so, please give their names and addresses_____

Please give the name and address of your personal physician (s), dentist (s) and pharmacist (s)_____

IT IS UNDERSTOOD AND AGREED that if the Board of Trustees makes the loan herewith applied for:

(1) No interest shall be charged on the principal until I have received my degree, or diploma, in the course of study for which this loan is made, or until I have terminated my course of study prior to receiving such degree or diploma, except that interest shall not be charged in the case of a student in medicine or pharmacy until completion of internship.

(2) Where my withdrawal from school is temporary, as for reasons of health, interest will be suspended during such temporary withdrawal as long as it does not exceed one year.

(3) The Board of Trustees may ask of me reasonable security at any time for the debt, should it feel it necessary.

(4) The Board of Trustees may require ordinary life insurance on my life in an amount at least equivalent to the principal sum of this and any other loans made to me by the Board of Trustees, or it may require credit life insurance on my life, and the premiums for any such insurance may be added to my loan.

/s/ _____ (seal)
Student

/s/ _____ (seal)
Guarantor*

_____ Date_____
Witness

*If the applicant is a minor and unmarried, it is necessary that a parent or guardian also sign the application and note.

For Your Information:

(1) File this application with the dean or director of your professional school who will forward it to the proper official of the Foundation.

(2) Students who receive loans are often provided with an ordinary life insurance policy with minimum benefits of $2,000. Premiums are paid by the Foundation and added to your loan. The policy insures the loan against your death, with excess being paid to your named beneficiary. Upon repayment, the policy is turned over to you and you may keep it in effect if you wish. Usually the policy will have cash value at that time. Further details will be provided you at the time this application is approved.

(3) Physicians donating to this account are periodically advised of its operation and while recipients of loans are identified, the amount of the loan is not.

* * *

STUDENT LOAN NOTE

Medicine_____ Pharmacy_____ Dentistry_____
Nursing_____ Other_____
Original Amount: $_____ Date_____
On or before_____, 19____, for value received, I (Name) _____, the undersigned, promise to pay to the Board of Trustees of the Charitable, Educational and Scientific Foundation, Inc. of the State Medical Society of Wisconsin, or order, the principal sum of this Note, as described herein, with interest at the applicable rate shown below, payable annually. The principal sum of this Note shall be the original amount $_____, plus the amount of all interest not paid on or before its due date, and plus the sum of all premiums which the Board of Trustees shall pay on any policy of insurance on my life assigned by me to secure this Note. The amount of said premiums shall be deemed to be their amount as determined by the policy less the amount of any dividends actually applied as credits toward premium payments.

I Further Understand That:

(1) No interest shall be charged on the principal until termination of my education, in accordance with the provisions of the loan application dated_____ and made a part hereof.

(2) In consideration for this loan, the Board of Trustees may make interest charges not to exceed four per cent (4%) per annum after termination of my education, in accordance with the provisions of the loan application attached hereto.

(3) Interest will be suspended if and while I am in active military service.

(4) The Board of Trustees may adjust interest charges in the following metnod:

a. If the Note is paid within one year of licensure or certification, an interest charge of two per cent (2%) per annum from the date of licensure or certification will be applicable.
b. If the Note is paid prior to the expiration of two years after licensure or certification, an interest charge of three per cent (3%) per annum shall be applicable, beginning with the date of licensure or certification.
c. If the Note is paid after the expiration of two years after licensure or certification, an interest charge of four per cent (4%) per annum shall be applicable starting with the date of licensure or certification.
d. If I should terminate my medical education before licensure or certification, the rate of interest applicable to this loan beginning with the date of such termination shall be four per cent (4%) per annum.

(5) When I am licensed or certified, annual interest shall be payable as follows:

a. On first anniversary of licensure or certification, three per cent (3%) of principal remaining unpaid;
b. On second anniversary of licensure or certification, four per cent (4%) of principal then remaining unpaid plus one per cent (1%) of principal as of the first anniversary of licensure or certification before the addition of interest; and
c. On each anniversary of licensure or certification thereafter, four per cent (4%) of principal as of that date.

But if I should terminate my education before licensure or certification, the annual interest payable on each anniversary of such termination shall be four per cent (4%) of principal unpaid as of that date.

(6) It is a condition of the loan for which this Note is given that I shall obtain ordinary life insurance on my life with an insurance company designated by the Board of Trustees in the amount of Two Thousand Dollars ($2,000.00) or the amount of this Note, whichever shall be the greater, and that I shall assign all my interest and that of my beneficiaries in the said insurance, up to the principal sum of this Note as security therefor.

(7) The loan is a moral as well as a legal obligation, and that the terms thereof shall be met promptly and honorably so that other needy students may be similarly aided.

I certify that: (1) The answers given in my application for a student loan are true to the best of my knowledge, and (2) I shall keep the Board of Trustees advised of any change in my address.
In presence of:

_____ /s/ _____ (seal)
Name Student

Address

_____ /s/ _____ (seal)
Name Guarantor*

Address

*In the case of an unmarried minor, it is necessary that a parent or guardian also sign the Note.

* * *

EXHIBIT B

DANE COUNTY HEALTH CAREERS LOAN FUND

The unanticipated surplus existing from the Sabin-On-Sunday program conducted in 1964 by the Dane County Medical Society on behalf of the citizens of Dane County,

with the assistance and cooperation of the pharmaceutical, dental and nursing professions, will be utilized for the financial assistance of residents of Dane County who are actively enrolled as full-time students in a recognized institution pursuing a course of study in one of these four health professions: medicine, pharmacy, nursing or dentistry. The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin will administer the fund, to be designated "The Dane County Health Careers Loan Fund," in accordance with the following rules:

1. The Foundation will furnish annually an accounting of the Fund to the Dane County Medical Society;
2. Applicants for loans must, at the time of application, be residents of Dane County;
3. Application blanks may be procured from the Foundation Office, 330 East Lakeside Street, Madison, and brochures, folders or other literature concerning the Fund may be distributed by any interested organization or person;
4. Applications will be accepted and considered without regard to race, color, creed or national origin;
5. The decision to approve individual loan applications, the amount of the loan and terms of repayment will be made only by the Foundation and will be based on the need demonstrated and availability of funds, except that repayment is to begin not later than one year following the student's completion of training in his particular field, with interest at prevailing rates charged for other student loans by the Foundation;
6. An applicant must be enrolled in an accredited university or college, pursuing a course of study in pre-medicine, pre-dentistry, pharmacy, medicine, dentistry or nursing, except that a student in the study of nursing may be either enrolled in a professional course of study at a college or university or a recognized school of nursing leading to a nursing diploma;

EXHIBIT B continued on next page

EXHIBIT C

CONTRIBUTIONS TO THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION BY MEMBERS OF COUNTY MEDICAL SOCIETIES

January 1, 1965—August 31, 1965

County	Number of Members	Voluntary Contributions in Response to Billing		Additional Contributions Memorials, "in Honor of," Ear Marked, Etc.	
		Number	Amount	Number	Amount
Ashland-Bayfield-Iron	19	17	$ 85.00	1	$ 25.00
Barron-Washburn-Sawyer-Burnett	33	32	160.00	2	15.00
Calumet	9	8	40.00		
Chippewa	24	24	120.00		
Clark	14	13	65.00	1	25.00
*Columbia-Marquette-Adams	31	30	150.00	2	40.00
Crawford	9	9	45.00		
*Dane	471	362	1,810.00	20	491.00
Dodge	48	36	180.00	1	5.00
*Douglas	25	25	125.00	2	35.00
Eau Claire-Dunn-Pepin	93	75	375.00	2	20.00
Fond du Lac	79	69	365.00	2	35.00
Forest	5	3	15.00		
Grant	31	28	140.00		
Green	41	5	25.00	1	10.00
Green Lake-Waushara	16	16	80.00	1	10.00
Iowa	11	8	40.00		
Jefferson	36	29	145.00	2	35.00
Juneau	6	5	25.00		
Kenosha	82	76	380.00	2	45.00
La Crosse	100	78	410.00	3	45.00
*Lafayette	6	—0—	—0—		
Langlade	17	12	60.00		
Lincoln	14	11	55.00	2	48.75
Manitowoc	49	30	150.00	1	10.00
Marathon	69	46	230.00	1	50.00
Marinette-Florence	20	18	90.00	1	25.00
Milwaukee	1,373	840	4,200.00	25	1,698.00
Monroe	15	15	75.00		
Oconto	9	8	40.00	1	10.00
Oneida-Vilas	28	18	90.00	2	35.00
*Outagamie	88	—0—	—0	3	140.00
*Pierce-St. Croix	34	31	155.00	2	15.00
Polk	24	23	115.00		
Portage	27	27	135.00		
Price-Taylor	12	12	115.00		
Racine	129	91	455.00	3	45.00
Richland	12	4	20.00		
Rock	114	98	490.00	2	15.00
Rusk	5	5	25.00		
Sauk	26	20	100.00		
Shawano	18	10	50.00	2	15.00
Sheboygan	78	71	355.00	5	110.00
Trempealeau-Jackson-Buffalo	24	24	120.00	1	10.00
Vernon	18	12	60.00		
Walworth	30	26	130.00		
Waukesha	113	101	510.00		
Waupaca	22	17	85.00	2	20.00
Winnebago	99	82	410.00	2	85.00
Wood	77	20	100.00	1	5.00
Brown	129	111	555.00	2	15.00
Door-Kewaunee	20	17	85.00	1	25.00
Ozaukee	18	17	85.00	2	50.00
Washington	30	—0—	—0—	1	15.00
	3,930	2,765	$13,925.00	104	$3,277.75

*See Contributions By County Medical Societies.

EXHIBIT C continued on next page

EXHIBIT B continued

7. The application form will be substantially similar to that used by the Foundation for medical student loans;
8. The Foundation may, at its discretion (a) require life insurance on the applicant, (b) accept additional contributions to the Fund, (c) accept accelerated payments of obligations to the Fund, (d) waive repayment in hardship cases and (e) increase or decrease rates of interest as the demands for loans may dictate;
9. The Foundation will equally apportion the loans approved so that the four health professions listed above will each receive an equal share for students of that profession, except that whenever the demands on one profession's share do not appear great enough to utilize the whole of that share during an academic year the Foundation may, at its discretion, and with the consent of the Dane County Medical Society, use a portion of that profession's share for loans to students of one or more of the other three professions, when in the judgment of the Foundation such portion would not be utilized during the ensuing academic year;
10. The Foundation may invest and re-invest assets of the Fund in accordance with prudent investment policies, and any interest or appreciation earned by such investments will accrue to the Fund;
11. Direct expenses incurred by the Foundation in administering the Fund will be charged to the Fund.

June 15, 1964

EXHIBIT C continued

BY MEDICAL SOCIETIES

	Amount of Contribution
State Medical Society of Wisconsin	$ 2,885.00
Columbia–Marquette–Adams County Medical Society	1,000.00
Dane County Medical Society	125.00
Douglas County Medical Society	50.00
Lafayette County Medical Society	100.00
Outagamie County Medical Society	15,000.00
Ozaukee County Medical Society	100.00
Pierce–St. Croix County Medical Society	25.00
Woman's Auxiliary to the State Medical Society	410.00
Woman's Auxiliary to the Marathon County Medical Society	16.50
	$ 19,711.50

BY OTHER ORGANIZATIONS AND INDIVIDUALS

Accent, Inc.	$ 100.00
American Cancer Society, Wisconsin Division	41.00
Clinic of Internal Medicine	100.00
Hollister, Inc.	50.00
Merck, Sharp & Dohme	1,008.07
NMC Projects, Inc.	750.00
Wisconsin Heart Association	200.00
Wisconsin Physicians Service	20.00
Wisconsin State Medical Assistants Society	50.00
Individuals (Memorial)	990.45
	$ 3,309.52
TOTAL	$ 40,223.77

■ STAFF REPORT ON BEHALF OF THE DELEGATION FROM THE STATE MEDICAL SOCIETY OF WISCONSIN, SPECIAL SESSION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION—OCTOBER 2–3, 1965

A special session of the House of Delegates of the American Medical Association was called upon request of 37 Delegates. This number represented one-third of the constituent associations as required by the Bylaws of the AMA.

The purpose of the meeting was to consider pertinent items relating to current problems incident to health care laws and pending legislation. Under constitutional requirements of the AMA this was the only business that could be considered at this particular session.

Preceding the Saturday and Sunday sessions, which were held in Chicago, a special meeting was arranged to acquaint members of the association with provisions of P.L. 89–97. This conference enabled those in attendance to hear from representatives of the Department of Health, Education and Welfare, and to give their advice to the special advisory committee to HEW appointed by the AMA.

The Friday meeting, which served as a prelude to the House session, was attended by delegates, officers and staffs of the constituent medical societies.

EMPHASIZING THE THEME OF PROTECTING THE STATURE OF THE PROFESSIONS . . .

was John W. Gardner, Secretary, Department of Health, Education and Welfare. Philip R. Lee, M.D., Deputy Assistant Secretary, Health and Medical Affairs, HEW; and Arthur E. Hess, Director, Bureau of Disability and Health Insurance, Social Security Administration, also spoke. The tone of the presentation clearly asked for cooperation from physicians in the implementation of P.L. 89–97.

WE KNOW HOW AND ARE PREPARED TO DO IT . . .

was the message concerning the insurance carrier's role in implementing the law. This was discussed by Walter J. McNerney, President, Blue Cross Association; Russell B. Carson, M.D., Chairman, Board of Directors, National Association of Blue Shield Plans; Howard Hassard, General Counsel of the National Association of Blue Shield Plans; and C. Manton Eddy, President of Health Insurance Association of America. The hospital's role was discussed by Edwin L. Crosby, M.D. of the American Hospital Association.

WE'LL ENDEAVOR TO WORK OUT PROBLEMS JOINTLY . . .

The afternoon session provided an opportunity for representatives to question the speakers on specific details of the law and on administration of the law. But, it was apparent that the regulations are not formalized and that it will require a great deal of time and effort to implement the provisions of P.L. 89–97. Doctor Annis, Past President of the American Medical Association, reviewed the problems that physicians face because of "medicare" and emphasized the reasons that P.L. 89–97 was passed over the strong objections of organized medicine.

Representatives of state medical societies met with the AMA Advisory Committee to HEW and gave suggestions on the implementation of "medicare" and their widely varying opinions of what the position of the AMA should be in this regard. The State Medical Society of Wisconsin was represented by J. H. Houghton, M.D., President; E. J. Nordby, M.D., Vice-Chairman of the Council; C. H. Crownhart, Secretary; and R. E. Koenig, Insurance Director. Mr. Crownhart remarked that he expected voluminous regulations and offered the advice of Wisconsin that when developed, medical societies should not be excluded from such role as they might be able to play; that any guideline fee schedules should be subject to society approval; and that

another such conference be held in Philadelphia to begin in the morning rather than at the tail end of a long day of presentations.

A complete transcript of all presentations made at the special conference on "medicare" is being made and any member of the Society can receive this information as soon as it is transcribed. Copies of speeches can be obtained from the American Medical Association when ready.

The House of Delegates has had two special sessions this year and the meeting on October 2 and 3 was the 5th special session in AMA history. At the opening session on October 2 the Chairman of the Board of Trustees reviewed the activities of the Association since the June meeting of the House and the committees that had been appointed to work on the implementation of P.L. 89–97. The report from the Chairman also summarized the positions adopted by the AMA in the June meeting.

After remarks from President James Z. Appel, M.D. appealing for unity among members of the profession, 43 resolutions were referred to the Reference Committee on Legislation and Public Relations. These resolutions dealt with subjects ranging from pledges on non-discrimination to the desired relationship between the AMA and the executive branch of government. Also included was the Wisconsin resolution which appears at the end of this report.

The Reference Committee convened at noon on Saturday and heard 125 speakers who forcefully varied in their feelings on the proper physician approach to "medicare" and other government health programs.

Because of the number of resolutions introduced, and because of the interlocking relationship of many of these resolutions, the Reference Committee on Legislation and Public Relations presented a series of numbered comments, principles and policies which expressed the position of the AMA on the issues under consideration. (Copy of this report was distributed to the Wisconsin House of Delegates.)

In summary, the House approved the principle that a physician acting independently must make his own decisions as to the degree of his participation in the program.

Ethical considerations in the freedom to choose patients and embodied in Sections 5 and 6 of the Principles of Medical Ethics were reaffirmed, but it was pointed out that under some circumstances, the physician's freedom to select his patients may be circumscribed by overriding ethical considerations. For examples see the AMA Reference Committee report.

The following statement was adopted by the House in an attempt to clearly summarize the position concerning the right to choose patients:

> "The American Medical Association opposes any program of dictation, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89–97."

In considering the regulations that must be composed to implement P.L. 89–97 it was agreed that the AMA should continue to meet with representatives of agencies and departments of the federal government. It was also stated that physicians should be encouraged to render whatever advice and assistance they can so that regulatory changes can be suggested or sponsored by the AMA in order that the best interests of the public and the profession will be served.

The House also directed the AMA Advisory Committee to HEW to make certain that current practices and customary procedures with respect to physician certification for hospital admission and care be continued under "medicare."

Policy statements with respect to carriers and disputes on fees can be found in the AMA Reference Committee report.

Note: County medical societies will be kept advised of such role as may be expected of them, and since there is a well-established procedure in Wisconsin, it is contemplated that Wisconsin will follow practices under the Special Service (no fee schedule) contracts.

The House adopted the position that hospital utilization review committees should be composed of practicing physicians and a conference on the subject of utilization will be held in connection with the November meeting of the House of Delegates in Philadelphia.

In regard to compensation for medical services, it was directed that physicians should be informed on the merits and limitations of billing patients directly for services, or accepting an assignment to enable payment by a federally designated fiscal intermediary. This is to be done so that the physician can decide for himself in each instance the method of compensation which he prefers.

In other actions the House of Delegates asked the Council on Medical Service to continue its review of the shortage of hospital beds and asked for continuing surveillance on the problem being incurred because a number of state agencies require pledges of non-discrimination for the purpose of meeting the requirements of Title VI of the Civil Rights Act.

In addition to expressing confidence in the Board of Trustees, the Advisory Committee to HEW, and the recently appointed consultants to the Advisory Committee, the House reaffirmed the principle of separation of professional fees and hospital charges. In connection with the separation of professional fees the following statement was adopted:

> "Hospital based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians. The American Medical Association intends to continually, and vigorously oppose the inclusion in the future of the professional services of physicians in any hospital portion of any health legislation."

It seemed to be the opinion of most Delegates that the meeting served a very useful purpose in making clear the policies of the AMA and in advising the physician committees on the appropriateness and the extent to which they should be willing to work with the government in implementing this law.

The length and diversity of debate makes it difficult to adequately summarize the "tone" of the meeting but it is felt that this report will give all members of the Society the thinking presented and the attitudes that prevailed among the majority of the delegations represented.

More details of the meeting, and more information on actions taken by HEW will be made available in coming weeks. In the meantime, every physician is urged to carefully read the AMA NEWS and the JAMA so that he will be acquainted with actions taken, new positions developed and recommendations being considered in this law which is of vital and unquestionable concern to the American way of life and to the practice of medicine.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 23 (S/2–65)
Introduced by: Wisconsin Delegation
Subject: P.L. 89–97

WHEREAS, The State Medical Society of Wisconsin on August 1, 1965, considered its professional obligation in matters pertaining to the administration of Medicare; and

WHEREAS, It adopted a statement which reads as follows:

"Medicare has now become the law of the land through the democratic processes of our country, processes of which we may all be proud.

"During debates upon the measure, the medical profession voiced its opposition, its reasons for that opposition and presented alternative proposals. That is a fundamental privilege of the democratic process, a privilege which all citizens must cherish and protect.

"But now that Medicare is law, the State Medical Society of Wisconsin, through its members, will provide full measure of constructive leadership in its administration. Where we find improvement necessary, we will speak up. Where deficiencies become obvious, we will not hesitate to point them out. And where the law is effective, we will express our opinion on that as well.

"Since this law is now a fact, it will require the kind of leadership that the medical profession, and only the medical profession, can provide. We will provide it.

"Nothing less than that could we do in good faith to our patients and in satisfaction of our professional and civic conscience"; therefore be it

Resolved, That with appropriate editing this statement become the position of the American Medical Association.

■ 1966 PROPOSED BUDGET, STATE MEDICAL SOCIETY OF WISCONSIN—OCTOBER 1965

Anticipated SMS Income, 1966

Dues, all membership classifications	$350,000
This assumes dues remaining at the 1965 amount and is a conservative estimate because of the fact that we cannot predict how many additional physicians will come into Wisconsin during the year.	
Wisconsin Medical Journal, *advertising*	35,000
Annual Meeting	28,000
Dues, Section on Medical History	1,500
These funds are not available for general Society purposes, but rather to implement activities of the Section on Medical History, aid in the acquisition of memorabilia and the development of exhibits.	
Reimbursement from Dane County Medical Society	2,700
The costs of doing a certain amount of clerical work in maintaining records of the Dane County Medical Society.	
Reimbursement for work performed, and supplies used, for other divisions including Field Service	14,000
Certain work performed as a Society service is actually in behalf of the Realty Corporation, WPS, and other activities. These services are charged out periodically and while treated as income, this actually is a not-for-profit operation. This amount includes $10,000 anticipated as a charge to WPS for certain work conducted in field service.	
Miscellaneous (reprints, bound copies of Open Panel, etc.)	1,500
	$432,700

SMS Proposed Budget, 1966

Account Title and Description	*Normal*	*Special*
Dues	$ 1,450	
The Society is a member of such organizations as the Better Business Bureau of Milwaukee, Wisconsin Council of Safety, Professional Convention Management Association, and the American Public Health Association. It supports with five other states the North Central Conference and participates in the Conference of Presidents and Other Officers of State Medical Societies. It also supports the National Society for Medical Research (animal experimentation) and is a member of the Wisconsin Health Council.		
Conference Expense	$ 25,750	
Council and committee meetings including travel expenses billed by physicians and consultants		
AMA delegates' and alternates' expenses for meetings in Chicago and Las Vegas		
President's travel allowance, in- and out-of-state Annual Meeting expenses of Society officers, committee members, facilities for House of Delegates, luncheons and dinners (largely recovered in income)		
Special meetings to discuss interprofessional and other problems; expenses of attending national conferences		
Interim House of Delegates meeting		
Promotion	$ 6,100	
Costs of educational exhibits; photographs for news releases and other promotion; pamphlets for special distribution; public information services such as First Aid Charts; general Society promotion		
Promotion cost for annual meeting such as printing of programs and announcements in WMJ (recoverable in income)		
Depreciation	$ 3,000	
Computed at current rates on existing equipment and projected for equipment purchases in 1966		
Grants and Appropriations	$ 3,700	
Support of State 4-H activities		
CES Foundation to support teaching programs		
Governor's Committee on Employment of Handicapped		
Student AMA Chapters		
*Aid to needy physicians		
Insurance, General	$ 2,500	
Annual cost of basic insurance including bonding of employees and officers, fire and liability		
Travel accident policy		
Miscellaneous Expense	$ 3,000	
An amount normally provided for items not related to other account classifications		
Annual meeting miscellaneous items (recoverable in income)		
WMJ miscellaneous (partly recoverable)		
Office Supplies and Expense	$ 3,000	
Normal requirements for mimeograph stencils, IBM forms, Xerox, carbon paper, ribbons, files, vouchers, card stock and other items		
March of Medicine tapes and mailing cases		
Annual meeting badges		
Outside Services	$ 7,400	
Clipping services		
March of Medicine recording		
March of Medicine emcee, Doctor Tenney		
Annual meeting expenses (recoverable)		
Manpower		
Miscellaneous charges		
Postage	$ 11,400	
Routine requirements		
March of Medicine, distribution of tapes		
Annual meeting (recoverable)		

*The Society, from the dues structure, maintains a fund of $1,000 in the CES Foundation from which grants are made on recommendation of councilors and officers of county medical societies when a physician is in need. This appropriation is not always needed, but some portion of it may be required each year.

Account Title and Description	*Normal*	*Special*
Printing and Forms	$ 44,950	
Wisconsin Medical Journal (estimated publication cost)		
Annual meeting items such as delegates handbook, registration cards (recoverable in income) Interim meeting handbook, etc.		
Badger Doctor's Wife and other Auxiliary printing		
Membership certificates		
Special legislative bulletins		
Routine printing and forms—stationery, envelopes		
Rent—Office	$ 39,000	
Space allocated to SMS and WMJ activities		
Rent—Other	$ 6,500	
Auditorium rental for annual meeting including services of furnishing, installing and removing signs and equipment for exhibits (recoverable in income)		
Rental—Equipment	$ 1,500	
Equipment rented for use at annual meeting (recoverable in income)		
Xerox copy machine		
Repairs and Maintenance of Equipment	$ 1,000	
Service agreements for addressograph, typewriters, dictating machines, and repairs to equipment		
Resource Material	$ 975	
Legislative Service		
Normal subscriptions and special publications		
Speakers' Expense	$ 3,500	
Annual meeting speakers' honoraria, hotel and travel expense		
Property Tax—Personal Property	$ 350	
Personal property tax on office equipment		
Telephone	$ 3,400	
Normal toll charges, telephone and telegraph		
Accounting Services	$ 6,000	
Services of independent CPAs to SMS and WMJ		
Legal Services	$ 5,700	
Legal services to the SMS in areas of general administration, grievance investigations, membership problems, etc.		
The above are routine services provided by legal counsel, but to an increasing degree special matters are presented during the course of the year which require action that cannot be anticipated at the time the budget is prepared. A contingency account of $5,000 is needed year in and year out.		$ 5,000
Legislative Retainer	$ 8,900	
Special Budgetary Provisions		$31,350
Town-Gown Symposiums		
Wisconsin Work Week of Health		
Conference on Health Fads and Fallacies		
125th Anniversary Year		
Special Public Information mailing list for Today's Health, AMA News and other special material		
Memorials to CES Foundation for deceased members		
Open Panels—1967 publication		
Contingency Fund		
Subtotal, Operating Budget	$189,075	$36,350
Staff Travel Expense	$ 10,000	
Staff travel related to Society activities, including annual meeting but excluding field service		
Possibly $1,000 of total is recoverable in income		
Payroll—except Field Service	$137,000	
Current payroll plus an amount for adjustments during the year		
Related Payroll Expenses	$ 20,000	
Pension plan contributions, Social Security tax, unemployment compensation, and group insurance, estimated at 15% of payroll		
Field Service	$ 39,500	
Two full-time field men and director, payroll and related expenses		
Travel, telephone and telegraph, and miscellaneous		
Total SMS Budget, 1966 — *Normal*	$395,575	
Special	36,350	
	$431,925	

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens. The Foundation administers these gifts in accordance with the stated desires of the donor and such gifts are deductible for tax purposes.

Among the many projects which are supported by this method is the medical student loan fund which has been given recent impetus by the donation of various surplus "Sabin on Sunday" funds from around the State and by significant donations from individuals.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

Research activity such as the Menominee County Health Survey which was presented to the fall 1964 interim session of the House of Delegates of the State Medical Society, the microscope loans, collection of medical stamps, and erecting appropriate historical markers denoting physician contributions to the history and welfare all go to make up the vast array of programs and services known as the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

PROCEEDINGS OF HOUSE OF DELEGATES

INTERIM SESSION • OCTOBER 9, 1965 • MADISON

SATURDAY MORNING SESSION

October 9, 1965

The first session of the House of Delegates of the State Medical Society of Wisconsin convened at 9:15 o'clock in the Presidents' Room of the State Medical Society Building at 330 East Lakeside Street, Madison, Wisconsin, with Dr. Robert E. Callan, Speaker, presiding.

Speaker Robert Callan: You will recall that at its 1959 session, the House directed that each future session be opened with the reading of Article II of the Constitution, which is entitled, "Purposes."

> "The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

The Speaker wishes to once again remind the House of Delegates that the House is a legislative body of the State Medical Society. Its processes are democratic. No delegate should hesitate to present his views. By precedent, discussion has been limited to five minutes for each speaker. This time may be extended by permission of the House, of course. Each member is to give his full name and county society he represents when he addresses the Chair.

REFERENCE COMMITTEE APPOINTMENTS

Announcement of reference committee appointments is made at this time.

I have appointed the following committees:

To the Reference Committee on Reports of Officers:

C. J. Strang, M.D., Barron, Chairman
H. F. Twelmeyer, M.D., Wauwatosa
M. V. Overman, M.D., Neillsville
E. D. Sorenson, M.D., Elkhorn
L. W. Schrank, M.D., Waupun

To the Reference Committee on Reports of Standing Committees:

W. T. Russell, M.D., Sun Prairie, Chairman
G. W. Hilliard, M.D., Milwaukee
W. F. Henken, M.D., Racine
C. A. Grand, M.D., Ashland
D. J. Twohig, M.D., Fond du Lac

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

G. E. Collentine, Jr., M.D., Milwaukee, Chairman
E. P. Rohde, M.D., Galesville
D. R. Griffith, M.D., Eau Claire
C. J. Picard, M.D., Superior
H. M. Suckle, M.D., Madison

REPORT OF CREDENTIALS COMMITTEE

The Credentials Committee is composed of Doctors W. D. Hamlin, Mineral Point, Chairman; Ann Roethke, Milwaukee; and C. E. Koepp, Marinette.

Dr. W. D. Hamlin: The Committee on Credentials has verified the registration of 45 delegates entitled to vote at this session of the House of Delegates representing 25 County Medical Societies and 6 Sections. This represents a quorum. A complete report of the Credentials Committee will be made later in this session.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 45, so compiled by the Credentials Committee, be accepted as the unofficial roll of this session of the House, at this time.

[Motion seconded and carried.]

Speaker Callan: At this time I would like to introduce representatives of the University of Wisconsin Chapter of SAMA.

APPROVAL OF 1965 ANNUAL MEETING PROCEEDINGS

At this time we come to the approval of the minutes of the 1965 Annual Meeting as printed in the supplement of the September issue of the WISCONSIN MEDICAL JOURNAL.

Dr. H. F. Twelmeyer (Milwaukee): I move they be approved as printed.

[Motion seconded and carried.]

ADOPTION OF STANDING RULES

Speaker Callan: Standing Rules of Procedure are stated on page 2 and 3 of the House of Delegates Calendar. What is the pleasure of the House? Does the House wish these be adopted as the standing rules of this session? The standing rules have been in order for many years in the past. What is your pleasure?

Doctor Twelmeyer: I move the adoption of the standing rules as written.

[Motion seconded and carried.]

■ REPORT OF THE PRESIDENT—OCTOBER 1965

President J. H. Houghton: In May of this year I subjected you to a rather long talk. You may rest assured that this report will be much shorter.

Since that time, what has happened? Medicare has become the law of the land and will come into effect on July 1, 1966. On one thing we are united—we all thoroughly dislike Medicare and consider it a bad law. However, opinion is divided among doctors all across the land on what to do about it. There are those who favor non-participation by the doctors, and they number quite a few. We in Wisconsin do not belong to this group. You are all familiar with the position of our State Medical Society from the policy statement that has been published. There are also those who criticize the AMA for forming a committee to consult with officials of HEW on regulations pertaining to Medicare. These individuals who criticize consider this to be collaboration. We don't. By consulting with HEW, this committee has an opportunity to aid in the direction that Medicare will go, and to safeguard to some extent the best medical care possible for the recipients.

This attitude on our part does not mean that we have capitulated, and it doesn't mean that we won't continue to fight for what we think is right. However, we are convinced that nothing we say or do will influence the present Congress. As Doctor Edward Annis so aptly said at the recent meeting in Chicago—"We didn't lose the fight in July when the bill was passed. We lost it in November, 1964 when the present Congress was elected." But how we will go about continuing the fight has not been crystallized, but I am personally convinced that it must be at the polls, and at the grass roots level.

Another aspect of Medicare is the formation of Utilization Committees, which again is going to involve all of us who work in hospitals. The AMA has or will have soon, a handbook on this subject which will be sent on request.

This year we have initiated a program to get doctors to know more about Student AMA, and to get these students to know more about our organized activities. The officers of the Student American Medical Association were at our Council meeting yesterday, both from Marquette and Wisconsin. These are fine young men and young women, and we must remember that they will become the future active members of our Medical Societies. Anything we can do to inform them and encourage them will be very much worthwhile now and in the future.

Our Town and Gown relationship, I believe, has been further improved by the Reception which was held at the State Medical Society building on September 19, 1965 for the Dean of the University of Wisconsin Medical School, Doctor Peter Eichman. This was well attended and created a feeling of good will all around. There will be a similar reception for Doctor Kerrigan, the new Dean of Marquette University Medical School in the near future.

There are many more things I could talk about, such as the Regional Medical Complexes bill which was signed recently, but I promised to keep it short and just hit the highlights. You will get additional information from the report of the Secretary, the report of the Delegates to the AMA and others.

I will close by saying that we are living in troubled times and it will take the utmost in cooperation from all of us for medicine to continue to furnish the high quality of service which it does at present. If we all work toward this end and devote our full efforts to it, I'm sure it can be done.

■ REPORT OF THE AMA DELEGATION

Dr. E. L. Bernhart: I believe most of you folks read the newspapers last week, and even heard on television that the Wisconsin Delegation spokesman, Dr. "Sarah" Bernhart vigorously opposed participation, that he would sooner go to jail than participate in the Medicare program.

I am very capable of saying this particular thing, but I was not the quoted individual. The individual who made these remarks came from one of our neighboring states, but I was given due credit and got bombarded by patients, hospital administration, and a lot of other people. We were able to cut off the television news for the rest of the day, but it had already been published in the MILWAUKEE JOURNAL. They did publish a retraction the next day, but I wanted it definitely understood that Bernhart opposed this anti-participation movement. We supported the State Medical Society and introduced a very sound, sophisticated, simple resolution which was accepted by most of the states in their caucus.

I was a little shook up, and it is hard to shake me, but this particular quote in the newspapers and the TV news which emanated from the United Press, I just want you folks to go back home and tell your people that Bernhart is bad, but not just that bad. [Laughter]

As the senior delegate from Wisconsin, I would just like to briefly mention what we did in Chicago last weekend. I think we came out of this thing with the very sophisticated public policy attitude of participation with a Federal law which is now in effect, and that we must all obey and do the utmost for our patients, number one, and try to salvage some of the things that we can for ourselves.

I feel that Medicare has passed. We got out of this thing a lot more than we went into it with the application of the free right of physicians, the freedom, voluntary insurance.

It was emphasized that the principles of medical ethics are applicable. The Bauer resolution, the nine principles which I think we are all acquainted with, were spoken about and adopted as the official policy of the Society.

The regulations under public law were testified to, and the policy of the House, I think, we should be justifiably proud of. It will be printed in the AMA NEWS, and I am not going to bore you with all the policy statements that were put out, but I think some of the things should be emphasized.

The intermediary insurance mechanism, which probably will be a matter of communication to you soon. AMA officially recommended Blue Shield as the intermediary agency because of their experience and their demonstrated ability to provide competent insurance programs in the past. The fee situation will be on a reasonable, customary and usual fee in the individual area. There will not be a national fee schedule. It will be an area type of situation, and any controversial things that do come up will be mediated through your County Medical Society Committee or the State Committee, if necessary.

The utilization committees that you have heard about, there will probably be three of them. Every hospital will have to have a utilization committee, and if there are small hospitals who only have a couple of doctors on their staff, they can call on a county medical society and provide a utilization committee, and then there will be a state utilization committee, and overseeing situation.

I do not know now whether there is going to be a recourse as to command, whether there will be an appeal mechanism. It may be that the county society or your own hospital society will be the final authority, but that will come out in the regulations of the HEW.

The non-discrimination situation that has been of great moment to a lot of us all over here, the signing of the stipulation that you will not discriminate because of race, color or creed, has been a subject of great moment in Ohio, Louisiana, and so on. But HEW has announced that they will not go further. They will not in the future ask for this particular signature. We know that it is implied.

AMA has given their particular consent for this particular type of participation.

Here is something that we are interested in. The hospital-based medical specialist will have to bill and collect in their own name any bills. We are talking now about the physiatrist, the pathologist, and the radiologist. There will be no more joint billings through hospital mechanisms.

I would like to say, too, that there was a lot of dissidence at this particular meeting. They were very vocal, and when the meeting went into an open reference committee of the House, everybody had an opportunity to speak, whether they were delegates or not. That is where I got myself in a jam. There were some of these boys that were very opposed to participation.

There is one thing that has been made very clear to us by the Judicial Council and also by the Counsel of the AMA, that anyone can choose not to participate as an individual, but not collectively or in

a group. Otherwise, they will be subject to the Sherman Anti-Trust Law, but I think that we as doctors and dedicated physicians from a great state with a great medical society will continue to do what we have in the past, that is, to support our government, and we will support the medical traditions that we so love and are dedicated to.

Dr. John M. Bell: Last weekend I was in Chicago, and this weekend I am here. This report should be subtitled, "A Funny Thing Happened to Me on My Way to the Packer Game." [Laughter]

I think Doctor Bernhart has well summarized what went on in Chicago. I was particularly impressed by the report of Mr. Hodson, the Chief Counsel for the American Medical Association. He said that the hallmarks of violation of the Sherman Anti-Trust Act would be group action in concert, action that resulted in restraint of interstate commerce, the fact that this was interstate commerce. and this would be a restraint of trade. He made it perfectly crystal clear that, if physicians acted in concert, that they would be in violation of the Sherman Anti-Trust Act.

Someone asked him why unions—and this, I suppose, goes through all of your minds—why unions weren't in violation of the Sherman Anti-Trust Act. And he explained, because of the Clayton Act and the Norris-LaGuardia Act, that they had been "excused" from this violation.

I have nothing much more to add except that the reference committee did a superb job. This reference committee was chaired by Doctor Montgomery of Illinois. The 125 speakers got national publicity, some of them that they didn't want to and were misquoted, and I agree that Doctor Bernhart was totally misquoted.

This session of the Reference Committee of the Joint House lasted seven and one-half, somewhat dreary hours.

■ SUPPLEMENTARY REPORT OF THE COUNCIL —OCTOBER 1965

[This report appears on page 495 of this issue.]

Vice-Chairman E. J. Nordby: I would also like to announce at this time that I am here by virtue of Dr. Fox's illness, who is Chairman of the Council, who has had several episodes of difficulty, but I am pleased to report is progressing well.

■ REPORT OF THE SECRETARY—OCTOBER 1965

Mr. C. H. Crownhart: You have a good many meetings in this room. Next February, for example, there will probably be upwards of 1,500 or 2,000 people here, attending affairs of the Work Week of Health. When there are meetings of some size, we distribute a little pamphlet which says, "Welcome to our home," and this tells of the exhibits in the building and some of your activities. We didn't think it would be quite proper to distribute to you a pamphlet entitled, "Welcome to our home." It is your home, and I hope that as you see staff members and have any questions, we may not be able to answer them on the spot, but here is the chance to see the workings of your Society once again.

My report to you from some notes that I made during the day yesterday has several aspects, some relating to Medicare, and I would like to tell you that when there is a law on the books of our country or our state, its contents and its provisions, although they may be specialized, of necessity are of interest to any citizen. I have at least one view on Medicare, and it is that the matter of non-participation has been blown up, I think, beyond proper proportions, so that we see in the paper today so often: "AMA Okays Boycott of Medicare," and then you read the story, and it is that the AMA says that an individual physician may do that if he wishes to, but organized medicine cannot. That is correct, but the point is that the AMA did not urge boycott of Medicare, and the newspapers' reporters, many of them—not all of them, of course—tend to lift some sentence out of the structure of a report and to use that as a policy statement.

I think you would participate if there were no Sherman Anti-Trust Law, and I make that statement here as I have made it elsewhere.

We might want repeal or change in the basic law itself, but medicine's dedication to public health and to the welfare of people is too deep-seated to be destroyed by a law that we don't like.

I come to another phase of Medicare. In the special session of the AMA, the last one, much question was raised by many people on the point of whether a member of a hospital review committee or a member of the county review committee incurred personal liability, libel and slander, for example, or perhaps the discharge of a patient on recommendation of that committee, who, after discharge, suffered some unforeseen development, whether the members of the review committee accepted for themselves a legal responsibility.

Lawyers can't always prognosticate with accuracy, and I might add that neither can physicians at times, I understand. We don't think so, but the Council has directed our associate counsel, Mr. Kluwin of Milwaukee, and our general counsel, Mr. Murphy, to study various phases of this prior to next July to see if it is not possible, if it is at all necessary or advisable, to seek some change in the liability insurance protection that doctors have so that coverage would be provided should such a claim ever be made and ever proved successful.

We can't anticipate what might be said. Trying to put the Good Samaritan principle into Medicare would certainly not be a popular legislative move. I wanted to inform you of that so that you will know that we are alert to the problem, even though we don't know the answer.

And then I would like to go to 1966 and the balance of 1965 in relationship to the staff of the State Medical Society. As Doctor Nordby said, there have never been two special sessions of the House in one year before. Neither were two special sessions in our budget, nor has all this activity been without impact on the staff.

I have recommended to the Council in consideration of your budget for 1966 that I think the best thing to do is to delay or postpone or lay over some of our more traditional activities, and a six-month delay is not going to damage them particularly, in order that the staff have the time necessary to aid you and aid the Council and officers in relation to Medicare.

I think we can adopt more resolutions perhaps, but we don't have to circulate them and spend time in multiplication of paper work in light of this pressing need.

You should be aware that Medicare and its financing will have an impact not alone in this area of health care, but on the costs of your office of this organization, any manufacturing concern throughout the country. One very large concern estimates that its operating cost will go up approximately one percent as the new taxes come into effect, and if it is going to have that kind of effect in the manufacturing field, it will certainly have it across the board.

I think that we can look at our problems of administration better next May or next October than we can anticipate them today, and in the meantime, we will gear up or gear down as the case may be.

I would like to talk with you for a moment about the CES Foundation, Charitable, Educational and Scientific. It has been the wish of the Council and the officers and the House of Delegates that that Foundation be fully staffed. Mr. Salt, formerly office services director here, has been assigned the function of director of the Foundation, and he has been provided with stenographic assistance which has been desperately needed.

The Foundation has well over $100,000 out on loan to medical students, and because of the generosity of Dane County, Outagamie and Marinette County—I shouldn't have started naming them unless I remember them all—Grant County—excess SOS funds have been made available on an equal basis to students of medicine, students of dentistry, students of pharmacy, and students of nursing, and so there has been quite an expanded loan program that developed as a result of those funds coming into the Foundation.

The project of Prairie du Chien is rapidly becoming more successful. It has been successful. By the end of this year—and it is really about two and a half full years of operation—there will be well over 50,000 to 75,000 people through there, and now the type of attendance is growing which we had hoped for and anticipated, that of school children being brought by bus to see the displays, and particularly our transparent gals, the two transparent figures who are taped to a recording that is exceedingly well done.

The Foundation trustees met here about a month ago, and made no recommendation with reference to the voluntary dues for 1966. I make my own recommendation to you, that since they are voluntary, they at least could be in two figures instead of one, and I would recommend to the House and to the Reference Committee that voluntary dues if you can call them dues when they are voluntary, be set at $10.00 this ensuing year.

About $13,000 or $14,000 has come in to implement the Foundation, but more funds are needed beyond staffing alone.

Now, I come to my final point, and that is the May meeting in La Crosse. I would like to say to you that all of us are a bit new at running a meeting outside of Milwaukee, but it has been a distinct pleasure to meet with the committee of the La Crosse County Medical Society representing all four hospitals in that area, and representing a huge amount of interest in making the La Crosse meeting a success.

The staff is jubilant. It feels that success is measured by interest as well as by size of attendance, and that La Crosse promises to please exhibitors and the public to an extent that I think will set a precedent for meeting out in the state elsewhere in the future.

I know that efforts are being made in Milwaukee to provide a special train to La Crosse which will probably stay overnight, maybe over two nights. We are making plans to run at least one special car, if not two, on the Hiawatha, so that Marquette students can come up, and we will provide buses out of Madison so that Madison students may come.

The House of Delegates has been so set that you will be able to attend every scientific session. That ought to be a novel experience for you.

We hope to conclude, even Doctor Bernhart, and others—we hope to conclude so that we don't conflict with the golf tournament. That ought to be another novel experience.

There is promise of entertainment. The work of the House, we hope to be able to streamline, and I am sure we can if we use our administrative techniques to the best advantage.

I think you will enjoy a La Crosse meeting very much, indeed, and it will be an historic one, marking our 125th Anniversary.

SUPPLEMENTARY REPORT OF THE CREDENTIALS COMMITTEE

Doctor Hamlin: The Committee on Credentials has verified the registration of 57 delegates and 15 alternate delegates entitled to vote at this session of the House of Delegates representing 35 County Medical Societies and 9 Sections. Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend: James Wong for Crawford County.

I move that the attendance roll of delegates, alternate delegates, and specially appointed delegates, totaling 72, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

■ REMARKS OF THE SECRETARY

Mr. Crownhart: There is nothing like speaking twice. I forgot something.

The Legislature, day before yesterday, accepted the principle of compulsory testing and reporting on PKU (phenylketonuria). I want to choose my words with care. It passed the Senate by a vote, I believe, of 28 to 1, and the Senate concurred in an assembly bill to the same effect.

It is trite to say that you can't be against sin. You can't be against motherhood and it is pretty darned hard to be against the emotionally disturbed parents and the retarded children, particularly when they appear in legislative halls, and we know of individuals who, of their own time, spent hours up there with reference to PKU.

Leaving out the fact that the state society failed to convince the Legislature that voluntary reporting and testing would accomplish the purpose, Mr. Kluwin and Mr. Murphy and myself yesterday sat in post mortem with reference to the precedent that has been established or is being established of a legislative body containing no one of scientific achievement, to the best of my knowledge, and Doctor Bolger isn't here, but there is one optometrist in the Legislature, and that is as close as anybody comes to knowing anything about the area of medicine. Calling upon a legislative body to determine a scientific issue. There are lawyers there, but they are not qualified. Many are farmers, mechanics, laborers.

Last spring a local TV station taped, put on video tape, a picture of a mother up in Fox River Valley talking about her retarded child and how, if PKU testing had been in effect, her child would be normal. And then that led into a view of Doctor Waisman and some others at the University, explaining the test and why it was necessary, and then into another view of doctors here in the community explaining why they were opposed to compulsory testing.

This was a flash-back. One doctor would say something. The other doctor would oppose. It was taped at different times in different locations, and the presentations were put together by the TV station.

This group was not brought in to one meeting and have them all sitting around the table.

To me, it was an experience that just really hurt to sit and watch that debate because it couldn't be put into language that the average viewer was going to understand. The only thing in its favor, I guess, it wasn't in color.

So after our conference yesterday, we came in to the Council and reported a recommendation in very broad terms that needs to be perfected, in which we suggest that the President of the State Board of Health, the President of the State Board of Medical Examiners, the Dean of the University of Wisconsin Medical School, the Dean of Marquette

University School of Medicine, and the President of the State Medical Society constitute an official state body before which any such proposals in the future—and somebody tells me that some 200 circumstances involving mental retardation are now under study—that any such proposal in the future would be presented to such a body.

It would have the power of any state commission. It would have to conduct public hearings. It could enact a regulation. More to the point, it could rescind a regulation that had become antiquated in time.

I hope that the Resolutions Committee, if it is this, or whoever gets it, understands that the basic purpose is to see that the science of medicine is kept as free as possible from legislative trammeling, and that, we hope to accomplish. The Council favored it. They told me to go before the Commission on Public Policy at an early date, draw up this legislation into more concrete form, and offer it, if possible, during this session. Not to head off PKU that has made its journey, and it is going to be up in the Governor's office before long, but to provide a protective mechanism in the future where the skills of two schools, public health, licensing of physicians, and with our President representing the State Society, where all those skills can be brought together into one pool to measure the validity of such proposals in the future.

Speaker Callan: To clarify one abbreviation that the Secretary mentioned before. SOS, in case some of you don't already know it, is "Sabin on Sunday" contributions from the SOS Funds of certain medical societies, those funds were derived from the Sabin programs which were called "Sabin on Sunday."

REFERRAL OF REFERENCE COMMITTEE REPORTS

So that delegates may be advised as to which reference committees will hear the various reports and recommendations submitted, this announcement is made upon the subject. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same committee.

To the Reference Committee on Reports of Officers:

The report of the Commission on State Departments, the report from the Division on Rehabilitation, and the report of the Commission on Medical Care Plans. Also, the President's Report.

To the Reference Committee on Reports of Standing Committees:

The report of the Commission on Public Relations and Communications, the report of the Committee on Occupational Health, the report of the Commission on Public Policy, and the Supplemental Report on Health Fads and Fallacies.

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

The Budget and Dues, the report of the CES Foundation.

Now as far as the supplementary report of the Council, which you were just given, Resolution A, dealing with the National Rural Health Conference, goes to Resolutions Committee. Resolution B, urging a separate cabinet post for all federal health activities, goes to the Resolutions Committee. Resolution C, about the physician-patient relationship and medical records under the administration of Medicare, goes to the Resolutions Committee.

Resolution D, the utilization review committee subject, goes to the Resolutions Committee, and the report of Mr. Crownhart.

The balance of the supplementary report of the Council is referred to the Committee on Reports of Officers. Included in this is the venereal disease resolution and the community health week resolution.

It is a privilege, as well as an opportunity for any interested member of the Society, to appear before these committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present.

The Reference Committees will meet upon adjournment of this present session.

As we all realize, the Reference Committees are the proper, official place for our delegates to transmit the feelings of their constituents for the benefit of the Society. There is where your words count. I think everyone is charged with bringing whatever is important before this official body.

Dr. Francis E. Gehin, Chairman of the Ad Hoc Committee on the Redistricting of the House of Delegates and the Council of the State Medical Society informs the Speaker that his committee will have an informal session immediately after adjournment. All delegates have been reminded by the Secretary's office of that provision of the Bylaws providing that all new business first introduced at this time must be introduced through the Council, constitutional officers, committees of the Society or the House or officers of the House.

Is there any further business properly to come before the House at this time?

Dr. F. D. Cook (Brown County): Before we adjourn, I just have a question. I noticed when we came in we had the blue folder this morning, which contains some of the reports which we have not had a chance to look at. Are these to be discussed in the Reference Committees, or is this to be laid over until lates on? We have not had a chance to discuss it or know anything really of the contents of it.

Speaker Callan: Yes, that report, that is the AMA Delegation report, prepared by the staff.

Doctor Cook: With details in it which I suppose we need to know.

Speaker Callan: The Speaker refers that to the Resolutions Committee, the Reference Committee. It will be discussed there.

Mr. Secretary, have you any other announcements?

Mr. Crownhart: In answer to that last point, this was a tough thing to get out as fast as it was, when we were in Chicago last Sunday. I do think, Doctor, that the five-page or six-page staff report summarizes pretty accurately the highlights of the Reference Committee report, but we provided the whole Reference Committee report to you in case you wanted further details.

There were more than 40 resolutions introduced, and only one of them was adopted. The other 40 were referred to the Advisory Committee, to the Board of Trustees. It seems pointless to put that prose, of which some of it was, before you, because there was no official action as such.

I would like to tell the House that it would be hard for me to introduce the staff that is present. I know Roy Ragatz in charge of scientific activities is here. Bernie Maroney who helps a great deal in the legislative field. Ray Koenig, insurance director, but I would like to identify our consultants. I can always recognize Murphy. Will you stand, Bob, for those who don't know you?

Now, next to him is an esteemed lawyer, former president of the State Bar, Jack Kluwin of Milwaukee.

And I saw the unusual stride of our consulting actuary. He always walks like the ship was rocking. Where are you Carl (Tiffany)?

Are any of the CPA's here? John White.

Also your experts appointed by the Council. Feel free to talk to them on any subject you wish.

Speaker Callan: Our Vice-Speaker, Doctor Behnke, was unavoidably prevented from attending today. This is not illness or anything too serious, but we certainly miss him up here.

Dr. C. J. Picard (Douglas County): Just a question to enlighten me and probably some of the others in regard to a matter that came up last year. The action was deferred. Would it be permissible to discuss this in the resolutions hearings this year, or do we have to bring it up on the floor again? I have reference to this Interim Meeting.

Speaker Callan: I would say that would be new business and would have to be presented according to the Bylaws by either the unanimous consent of the House of Delegates or the Constitutional Officers or the Council or Committees of the House or Officers of the House.

Doctor Picard: Could I offer that as a possibility to this House?

Speaker Callan: Did you wish to bring it up at this time?

Doctor Picard: Yes, sir.

Speaker Callan: Unanimous consent of the House is required for introduction of new business at this time. Is there any objection?

Dr. D. J. Twohig, Jr. (Fond du Lac): What is the exact nature of the business to be brought up that we are voting on?

Speaker Callan: The interim session of the House of Delegates.

Doctor Twohig: What about it? What about it?

Speaker Callan: Now, listen, is there any objection? If there's any objection to Doctor Picard bringing this up, we can't bring it up. Now, is there any objection from the House of Delegates?

Dr. H. F. Twelmeyer (Milwaukee County): Doctor, I object to bringing it up at this time.

Speaker Callan: Is there any other new business? [Laughter]

Hearing none, a motion for adjournment is in order.

Doctor Twohig: I so move.

[Motion seconded.]

Speaker Callan: It has been moved and seconded. All in favor?

We stand adjourned.

[House recessed at 10:15 o'clock.]

SATURDAY AFTERNOON SESSION

October 9, 1965

The House of Delegates reconvened at 3:30 o'clock, with Doctor Callan, the Speaker, presiding.

Speaker Callan: We will proceed with reports of the Reference Committees of the House. The first Committee to report is the Reference Committee on Reports of Officers, composed of Dr. C. J. Strang, Barron, Chairman; H. F. Twelmeyer, Wauwatosa; M. V. Overman, Neillsville; E. D. Sorenson, Elkhorn; and L. W. Schrank, Waupun.

Dr. C. J. Strang: Your Reference Committee on Reports of Officers is in complete accord with the attitude toward Medicare as already expressed by the president, Dr. J. H. Houghton, and we encourage further cooperation to strive for continued improvement in the plan.

We also commend the report of the president in respect to the work that has been done with the Student AMA groups and endorse and encourage this activity.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Strang: Your committee reviewed portions of the supplementary report of the Council. It notes the report of an increased incidence of venereal disease, endorses Resolution E, and recommends its adoption.

I so move.

[Motion seconded and carried.]

Doctor Strang: Your committee further endorses and recommends adoption of the Council resolution on Community Health Week, with insertion of one word, so that it reads as follows:

> *Resolved,* That the State Medical Society of Wisconsin endorses the observance of Community Health Week *sponsored* by the American Medical Association (November 7–13, 1965) and encourages the active participation of component societies in their respective communities.

I so move.

[Motion seconded and carried.]

Doctor Strang: Your reference committee noted Doctor Egan's interim appointment as councilor.

It endorses the action of the Council in commending the staff and the Wisconsin delegation to meetings of the House of Delegates of the American Medical Association. The action of the Board of Trustees of the AMA is also commended.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Strang: The report of the Commission on State Departments has been reviewed by the committee. It notes that the Commission has received approval of the Council to study the proposal by a legislative committee to discontinue the Diagnostic Center in Madison. Your committee heartily concurs that such study is necessary before final consideration is given to closing such facility.

Your reference committee recommends acceptance of the report of the Commission on State Departments as a whole, and I so move.

[Motion seconded and carried.]

Doctor Strang: Your reference committee recommends acceptance of the report of the Division on Rehabilitation as submitted to this House, and I so move.

[Motion seconded and carried.]

Doctor Strang: Your committee reviewed with satisfaction the report of the Commission on Medical Care Plans. It recommends approval of the report with commendations to the Commission and management for a job well done, with special note of the fact that operating expenses are within the ten percent goal of the estimated budget.

I so move.

[Motion seconded and carried.]

Doctor Strang: I now move adoption of this reference committee report as a whole.

[Motion seconded and carried.]

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Speaker Callan: The next committee to report is that on Reports of Standing Committees. Its Chairman is Dr. W. T. Russell of Sun Prairie. Other members are Doctors G. W. Hilliard, Milwaukee; W. F. Henken, Racine; C. A. Grand, Ashland; and D. J. Twohig, Fond du Lac.

Dr. W. T. Russell: Your Reference Committee on Reports of Standing Committees has reviewed the report of the Commission on Public Relations and Communications. Health education programs conducted by the Society, speakers service provided to both members and non-members of the Society, and other areas of public relations are outlined in this report. Your Committee commends the Commission

for its activities on behalf of all members of the Society. Special commendation is unquestionably due to Dr. H. Kent Tenney, Jr. for his direction of the March of Medicine, and for the personal attention that he has given listeners to this program which is carried weekly on 54 radio stations in Wisconsin.

Your Reference Committee would also like to point out that the Commission on Public Relations and Communications has worked with the Wisconsin State Medical Assistants Society in attempting to give Society aid and support to this group.

Your Reference Committee recommends acceptance of this report.

I so move.

[Motion seconded and carried.]

Doctor Russell: In reviewing Report No. 2 submitted by the Committee on Occupational Health of the Commission on Public Relations and Communications your Reference Committee would like to call attention to the publication, "A General Guide for an Occupational Health Program for Hospital Employees." This guide was published as a cooperative effort by several agencies and the State Medical Society's participation in the publication of this guide was under the direction of the Committee on Occupational Health.

The Committee on Occupational Health in its report also recommends that occupational health clinics be reactivated, under the auspices of the CES Foundation, with the first scheduled for Milwaukee in November of 1966. Your Reference Committee endorses this recommendation.

I move acceptance of this portion of the Report of the Reference Committee.

[Motion seconded and carried.]

Doctor Russell: Your Reference Committee also studied the Report of the Commission on Public Policy and commends the members for this exhaustive analysis of legislative positions adopted by the Society. The Reference Committee would like to note that the Commission supported 36 bills and opposed 12. It was pointed out in the report that three bills were supported for each one which was opposed, and it is felt that this is significant in light of the fact that medicine has been accused of primarily opposing legislative action.

Many of the bills mentioned in this report have been discussed previously by the House of Delegates, but the Reference Committee feels that special emphasis should be given to some bills which are of immediate interest and concern to public health.

Five bills have been introduced to extend the battered child law which was enacted in the 1963 session of the Legislature. Three bills have passed the Assembly and they all have amendments urged by the Society. These amendments free physicians from threat of legal action when they report suspected causes of child beating to authorities.

The Commission also reported on pending legislation which would give chiropractors the right to use the title "doctor;" this legislation has passed the Assembly and is now pending consideration by the State Senate. The Society is on record as opposing this attempt by chiropractors to confuse the public over their qualifications and their continued efforts to gain professional stature by legislation rather than education.

Your Reference Committee recommends that all State Senators be once again advised of the inherent danger to public health that legislation of this type affords.

The report of the Commission on Public Policy also includes a summary of optometric bills. Your Reference Committee concurs with the previous position adopted by the Society that the proposal embodied in Bill 368, A. which is designed to restrict the physician in his proper use of the dispensing optician, be opposed. It is also recommended that the Commission continue to oppose legislation of this type which would be injurious to the health and welfare of all patients.

The House heard in the first session this morning that two bills which would require mandatory testing for PKU have passed the Senate. Your Committee urges that the House of Delegates reaffirm its position of opposition to this legislation which would require testing to be done on a compulsory basis, and that attempts be made to assure that when tests are performed, that they can be performed by any qualified laboratory in the state.

I move acceptance of the Report of the Commission on Public Policy.

[Motion seconded and carried.]

Doctor Russell: The Supplementary Report of the Commission on Public Policy dealing with the Wisconsin Conference on Health Fads and Fallacies was considered by the Reference Committee on Standing Committees. Your Reference Committee feels that programs of this type are of inestimable value to health education and should be continued for the purpose of combating health fads and fallacies which exist in Wisconsin. The recommendation of the Commission that it investigate the feasibility of conducting a conference in Milwaukee with the assistance and cooperation of the Medical Society of Milwaukee County was discussed by the members of your Reference Committee who feel that this recommendation deserves the support of the House of Delegates.

The Reference Committee also concurs with the Commission on Public Policy in its recommendation that there be increased activity, under the direction of the Commission on Public Relations and Communications to further encourage requests from the general public for physician speakers, films, pamphlets and exhibits on the problems presented by health fads.

I move approval of this Supplementary Report of the Commission on Public Policy.

[Motion seconded and carried.]

Doctor Russell: I now move adoption of this report as a whole.

[Motion seconded and carried.]

REPORT OF CREDENTIALS COMMITTEE

Dr. C. E. Koepp: The Committee on Credentials has verified the registration of 35 delegates and 11 alternate delegates entitled to vote at this session of the House of Delegates representing 30 County Medical Societies and 4 Sections.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend: Dr. L. M. Pippin for Richland County.

I move that the attendance roll of delegates, alternate delegates, and specially appointed delegates, totaling 47, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

■ REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Dr. G. E. Collentine: In opening hearing this morning and in executive session this afternoon, your Reference Committee on Resolutions reviewed the resolutions and reports referred to it.

This Reference Committee considered the 1966 budget as forwarded by the Council and recommends its acceptance without change in the present dues amount of $100.

I so move.
[Motion seconded and carried.]

Doctor Collentine: The Committee reviewed the informational report of the CES Foundation and commends the activities of this Foundation, particularly in the area of loans to medical students. The Reference Committee believes that additional funds must be forthcoming if the Foundation is to continue effective activities in scientific teaching, public health education, and student loans. It recognizes and heartily endorses the practice of memorial and other donations by individuals, county medical societies, and other organizations. However, further strengthening of the administrative structure will require additional funds. Therefore, the Committee recommends that the following statement be inserted in annual billings for Medical Society dues:

"A voluntary contribution of $10 to the CES Foundation was recommended by the House of Delegates in October, 1965."

I move acceptance of this portion of the report.
[Motion seconded and carried.]

Doctor Collentine: Resolution A recommends support of the invitation for a national Rural Health Conference in Milwaukee. The Committee recommends adoption of this resolution with a minor change in wording, to read:

"*Resolved,* That the House of Delegates invite the American Medical Association to conduct a National Rural Health Conference in Milwaukee at the earliest possible date."

I move acceptance of this portion of the report.
[Motion seconded and carried.]

Doctor Collentine: Resolution B urges the establishment of a separate cabinet post of Secretary of Health, who shall be a properly qualified Doctor of Medicine. Your reference committee recommends its adoption.

I move acceptance of this portion of the report.
[Motion seconded and carried.]

Doctor Collentine: Resolution C proposes a means to assure respect on the part of government employees administering Medicare for the confidential nature of physician-patient relationship and medical reports. The committee recommends the insertion of the words, "standards of" between "ethical" and "conduct" in the third line of the first resolved, so that the resolution would then read:

"*Resolved,* That the State Medical Society of Wisconsin be on record that appropriate steps should be taken by the government of these United States to promulgate special ethical standards of conduct for government employees which will protect the patient, assure that the physician-patient relationship is not destroyed and that the confidentiality of medical records is guaranteed; and be it further

"*Resolved,* That this resolution be transmitted to the Wisconsin Congressional delegation and others of prominent influence."

I move acceptance of this portion of the report.
[Motion seconded and carried.]

Doctor Collentine: The Committee next considered Resolution D, relating to Medicare. It recommends that the resolution be accepted in the following revised form:

"*Resolved,* That the State Medical Society of Wisconsin ask that all of its component medical societies take immediate steps to create, where necessary, and to implement in all cases appropriate programs of utilization review to serve all hospitals and extended care facilities in their respective jurisdictions to the extent that such hospitals and extended care facilities do not have their own duly established programs; and be it further"

And this is in addition to Resolution D:

"*Resolved,* That the State Medical Society endorses the full statement of the House of Delegates of the American Medical Association that 'hospital utilization review committees shall be composed of practicing physicians'; and be it further

"*Resolved,* That the State Medical Society pledges its assistance to component societies in fulfilling the requirements of the law and its implementation in the public interest; and be it further"

And this is additional:

"*Resolved,* That the State Medical Society disseminate information and recommendations on legal responsibilities and other problems as they become available from the Advisory Committee on Hospital Utilization Review Committees of the Commission on Medical Care Plans or other sources; and be it finally

"*Resolved,* That copies of this resolution be provided all interested parties, including hospital organizations, national organizations, governmental agencies, and other associations of professions."

I move acceptance of this portion of the report.
[Motion seconded.]

Dr. Louis Olsman (Kenosha): In the first paragraph of this resolution, the term, "extended care facilities in their respective jurisdictions." I think we are getting into an area that we should either further define or discuss a little bit. I assume this to mean proprietary nursing homes perhaps, or county-controlled nursing homes or things of that nature.

In many instances, we as physicians, have no direct control over the operation of these nursing homes other than perhaps to refer a patient to them. I think it perhaps behooves us to either elaborate on this point or delete it at the present time.

Point 2, again, it is the same paragraph, where we recommend the setting up of utilization programs. Again, I think it behooves the Society to elaborate on this and define them more fully. Perhaps go into the areas that utilization should be looked into, and give the county societies more information before they set up these programs and then get lost in their own complications, because this is a very complicated thing, and I think that every county society will help in the effort at the state level.

Speaker Callan: Did you wish to offer an amendment about the extended care facilities, or is there any other discussion?

Doctor Olsman: I would like to have the Chairman elaborate on what is included in that group facilities.

Doctor Collentine: I believe that some elaboration is incorporated in the Whereas's of that resolution, and I have asked for a copy of that.

It is my understanding that all hospitals that do not have utilization review committees will be required to form them, and that in instances where the structure of hospital staffs is such that utilization review committees are impractical, that county medical societies will be asked to provide those. This will almost certainly be true of extended care facilities other than hospitals, nursing homes, homes for the aged and so forth.

The purpose of this resolution is to stimulate local societies to interest themselves in this before some other agency takes over and dictates to doctors what they should be doing.

Now in the Whereas's, if you will look at Resolution D, on the green pages, from the supplementary report of the Council, which was submitted this morning, I think that what I have said will be elaborated a little bit, and that short of writing a volume on this, this ought to suffice.

Mr. Crownhart: At this time.

Doctor Collentine: At this time. That is a very good point.

We do recognize that the legal implications and other problems are going to arise, but we think if we wait for every possible loophole to be defined, we are going to be late in the field where we should be leading, much as we dislike to do so.

Doctor Twelmeyer (Milwaukee): I would just like to know in a community such as Milwaukee where there are many, many nursing homes, would this mean a county society would have to provide utilization committees for these various homes or check on these places? This would seem to me to present a very considerable problem.

Doctor Collentine: I don't think I can answer that except to say that every extended care facility will have to have some sort of affiliation with a hospital, and whether or not the staff of that hospital is going to have to accept responsibility for review of utilization of those institutions or not, I don't think has been established, and I think the fact is that if county societies choose not to provide utilization reviews, somebody else is going to.

Speaker Callan: Is there any other discussion on Resolution D?

Doctor Twelmeyer: Just one question further. On the last Resolved: "That copies of this resolution will be provided all interested parties." How is this to be implemented?

Is this to be implemented on their request, or this to constitute a national mailing of some sort? That is a very indefinite statement.

Doctor Collentine: I agree. It was intended to be so, and probably at the discretion of the staff, and we hope, by direction of the Council. Do you think that ought to be incorporated in there?

Doctor Twelmeyer: Well, I would suggest that some limitation be placed upon a mailing which would be a considerable expense. I have no specific wording. I just ask for clarification. If it is the desire of the House that an amendment be made, I would suggest the amendment, "by direction of the Council," or "at the Council's discretion," be inserted.

Speaker Callan: Would you like to make that amendment?

Doctor Twelmeyer: I will make such an amendment.

Speaker Callan: There is an amendment then offered for the last Resolved: "That copies of this resolution be provided all interested parties including hospital organizations, national organizations, governmental agencies, and other associations of professions, at the discretion of the Council."

Is that correct?

Doctor Twelmeyer: Yes.

Speaker Callan: Is there any discussion on the amendment?

Doctor Bernhart: I second the motion.

[Motion on amendment to last Resolved, of this portion of the report, carried.]

Speaker Callan: Now, the vote is on the acceptance of this portion of the report as amended. Is there any discussion?

[Motion on report as amended, carried.]

Doctor Collentine: Your Committee recommends acceptance of the verbal report of the Secretary as presented to the House this morning and wishes to commend the Secretary and staff for efforts in behalf of the Society. The Committee endorses heartily the principle of state administrative body which can serve the public health by evaluating proposals relating to such matters as compulsory testing programs, where the expert fields of research and the practice of medicine can be combined through representation of the two medical schools, the State Board of Health and the State Board of Medical Examiners. The Committee recommends that this be referred to the Commission on Public Policy for further study and implementation.

I move acceptance of this portion of the report.

[Motion seconded.]

Doctor Twelmeyer: I would just like to say in relationship to this PKU statement in one of the preceding reports, lest we be taken out of context and be thought to be against motherhood, you know, it would be wise to point out that in this portion, or in this Reference Committee report, this has reference to situations such as the role of PKU testing, because this is where actually the stimulus for this part of the Reference Committee report arose. Isn't that so?

Speaker Callan: Yes.

Doctor Twelmeyer: So, I would think this. A little explanatory sentence would be inserted in this Reference Committee report to clarify the other Reference Committee report, so that someone can't take things out of context.

So, I would suggest an amendment to this portion of the Reference Committee report, saying that the recent action of the State Legislature in regard to compulsory PKU testing points up the necessity for a Commission of this sort.

Speaker Callan: An amendment has been offered to this portion of the report. Is there a second?

[Motion seconded and carried.]

Doctor Twohig: I thought it was the intention, too, or maybe it was just an oversight, that they intended, also, to include representation of the State Medical Society also in this group. I notice that they have the State Board of Health and the Examiners and the two medical schools, but I thought our President was going to represent us as an organization.

Speaker Callan: That is true. I will let the Chairman of the Reference Committee answer that.

Doctor Collentine: The Reference Committee unanimously endorsed the four representations included in the Resolution as presented and specifically excluded the State Medical Society because we think that the results in the PKU fight have labeled this as the kiss of death.

We feel that the representation mentioned could very well be considered more disinterested.

Speaker Callan: Thank you, Doctor Collentine. Is there any pertinent discussion on the amendment offered by Doctor Twelmeyer?

Dr. D. R. Griffith (Eau Claire): I oppose the amendment. While in principle, while in truth the proposal was actuated by the experience with the PKU testing, I believe that this proposal for a state administrative body has implications far beyond that of PKU testing. I believe the danger of the Legislature entering into legislative action to control the practice of medicine is very great. I think that the idea of setting up a body unrelated to things which have happened in the past is a very sound one, and I don't believe it would serve our best interest to tie this to what happened in the past, to PKU testing. I think we would stand a much better chance of getting this accepted if we did not.

Dr. W. T. Russell (Sun Prairie): As Chairman of the Public Policy Commission, I, too, would oppose this amendment for the same reasons as stated by Doctor Griffith. It would be much more effective if we had a proposal for overall problems rather than a specific answer to this bill.

Doctor Olsman: The makeup of the Commission as suggested in this resolution which includes . . .

Speaker Callan: Excuse me, Doctor. We are talking about the amendment now, identifying this portion of the report with the PKU.

Doctor Olsman: Doesn't that also include the inclusion of the present representation?

Speaker Callan: That will come next. We are working on the amendment right now. Is there any other discussion on the amendment?

The vote is on the amendment identifying the setting up of this Committee with the recent compulsory PKU testing. Is that right?

Doctor Twelmeyer: I think there might be a little misunderstanding of the intent of what I have in mind. I mean, we are now on record from the report of the Reference Committee on Reports of Standing Committees as being against PKU testing as compulsory. This is all right. This is well and good, except that this is open to public misinterpretation, and I think that the positive statement made in this particular pink report is of such importance that we should emphasize that we are not against valid things, but we have a better way of approaching the problem, and that is by establishing a Committee to review objectively such legislative proposals and acts, and this is the intent of the amendment, not to otherwise tie it in with PKU.

Speaker Callan: Will you please restate the amendment?

Doctor Twelmeyer: I would like to have the Secretary do that.

[Doctor Twelmeyer's amendment was read as follows:

"So I would suggest an amendment to this portion of this Reference Committee report saying that the recent action of the State Legislature in regard to compulsory PKU testing points up the necessity for a Commission of this sort."]

Doctor Twelmeyer: That is all I said.

Speaker Callan: Is everyone clear on the intentions of the amendment? Is there any more discussion on the proposed amendment?

Doctor Collentine: I am not satisfied that an amendment of that kind would permit incorporation into this resolution. I don't believe it is stated in a form that permits its incorporation.

Speaker Callan: The Speaker would have to agree with that.

Doctor Bernhart: Question.

Speaker Callan: The vote is on the proposed amendment that Doctor Twelmeyer offered.

[Amendment lost.]

The vote is now on the acceptance of this portion of the report.

Doctor Griffith (Eau Claire): You will note that the statement is in support of the principle of this program. It is felt that sufficient study—and I as a member of this Committee would agree that sufficient study includes membership of such a body—was not possible at this time in the short period of time in one day, and that is why we thought it would be best to refer this to the Commission on Public Policy for further study and implementation.

I don't believe in the wording of this recommendation the four men named are binding as the only men to be included on such a body.

Doctor Olsman: I still feel that as an official resolution of the State Medical Society there should be some provision for the representation of the private medical practitioner on such a Commission.

As it stands now, there is none other than perhaps an incidental member of the State Board of Medical Examiners—

Doctor Twohig: Or the State Board of Health.

Doctor Olsman:—because primarily you have a representative of medical schools. You have a representative of the State Board of Health, primarily men who probably or may not have been in private medical practice.

I think it behooves us to have someone representing the private practitioner.

Speaker Callan: Do you wish to make an amendment adding a representative of the State Medical Society?

Doctor Olsman: Yes, I do.

[Motion seconded.]

Speaker Callan: The amendment has been offered and seconded, to add to this portion of the report, in addition to the representation of the two medical schools, the State Board of Health, the State Board of Examiners, that there be a representative of the State Medical Society of Wisconsin.

[Amendment carried.]

[This portion of the report, as amended, carried.]

Doctor Collentine: This Committee considered the reports of the Wisconsin delegation and the staff concerning the special session of the House of Delegates of the American Medical Association. We recommend that the House of Delegates express its confidence in the Wisconsin delegation and add further endorsement to the program of the American Medical Association, as outlined in their report.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Collentine: I now move adoption of this report as a whole, on behalf of Doctor Rohde, Doctor Griffith, and Doctor Picard.

[Motion seconded.]

Speaker Callan: The motion has been made and seconded to adopt the report, as amended, as a whole.

[Motion carried.]

Mr. Crownhart: When I was introducing consultants this morning, I omitted reference to Jack Brown, the field man of the AMA, who serves Wisconsin and who is here so much I almost automatically have him on our staff. I think most of you met him during the day. He is in the back of the room, headed back for Chicago tomorrow.

Speaker Callan: Is there any new business to come before the House?

A motion for adjournment sine die is in order.

[Motion severally moved and seconded, carried.]

[House of Delegates adjourned sine die at 4:20 o'clock.]

■ ATTENDANCE AT HOUSE OF DELEGATES

	Sessions 1	Sessions 2
SOCIETY:		
Ashland–Bayfield–Iron		
C. A. Grand, Ashland	x	x
J. M. Jauquet, Ashland	o	o
Barron–Washburn–Sawyer–Burnett		
C. J. Strang, Barron	x	x
Robert Anderson, Cumberland	o	o
Brown		
B. P. Waldkirch, De Pere	o	o
Donel Sullivan, Green Bay	x	o
F. D. Cook, Green Bay	x	o
M. D. Blackburn, Jr., Green Bay	o	o
J. E. Dettmann, Green Bay	o	o
J. B. Grace, Green Bay	o	o
Calumet		
E. W. Humke, Chilton	o	o
J. C. Pinney, Hilbert	o	o

First name is delegate, indented name is alternate, x—present. o—absent.

	Sessions 1	Sessions 2
Chippewa		
M. W. Asplund, Bloomer	o	o
J. J. Sazama, Chippewa Falls	o	o
Clark		
M. V. Overman, Neillsville	x	x
E. D. Pfefferkorn, Colby	o	o
Columbia—Marquette—Adams		
R. T. Cooney, Portage	x	x
R. R. Rueckert, Portage	o	o
Crawford		
M. S. Garrity, Prairie du Chien	o	o
James R. Wong, Prairie du Chien	x	x
Dane		
R. N. Allin, Madison	x	x
W. P. Crowley, Madison	o	o
Robert L. Beilman, Madison	x	x
T. F. Heighway, Middleton	o	o
P. R. Kundert, Madison	o	o
J. H. Morledge, Madison	o	x
T. J. Nereim, Madison	x	x
K. L. Siebecker, Madison	o	o
W. T. Russell, Sun Prairie	x	x
A. V. Kanner, Madison	o	o
A. P. Schoenenberger, Madison	x	x
G. E. Oosterhous, Madison	o	o
R. A. Straughn, Madison	o	o
G. J. Derus, Madison	x	o
H. M. Suckle, Madison	o	o
P. G. Piper, Madison	o	o
Dodge		
L. W. Schrank, Waupun	x	x
R. E. Urbanek, Beaver Dam	x	x
Door—Kewaunee		
W. G. Sheets, Sturgeon Bay	o	o
Patricia Lanier, Kewaunee	o	o
Douglas		
C. J. Picard, Superior	x	x
R. P. Fruehauf, Superior	o	o
Eau Claire—Dunn—Pepin		
D. R. Griffith, Eau Claire	x	x
G. G. Giffen, Eau Claire	o	o
A. A. Drescher, Menomonie	x	x
W. R. Manz, Eau Claire	o	o
Fond du Lac		
D. J. Twohig, Jr., Fond du Lac	x	x
W. G. Kendell, Fond du Lac	x	x
W. E. Myers, Fond du Lac	x	x
James A. Sisk, Fond du Lac	x	x
Forest		
E. F. Castaldo, Laona	o	o
B. S. Rathert, Crandon	o	o
Grant		
C. L. Steidinger, Platteville	x	x
H. W. Carey, Lancaster	x	o
Green		
R. G. Zach, Monroe	o	o
W. J. Staab, Jr., Monroe	x	o
Green Lake—Waushara		
Russell C. Darby, Wautoma	o	x
David J. Sievers, Berlin	o	o
Iowa		
W. D. Hamlin, Mineral Point	x	x
S. B. Marshall, Hollandale	o	o
Jefferson		
M. G. Peterson, Lake Mills	x	x
R. R. Liebenow, Lake Mills	o	o
Juneau		
V. M. Griffin, Mauston	o	o
Jack Strong, Mauston	o	o
Kenosha		
Richard Powell, Kenosha	x	o
Walter Rattan, Kenosha	o	o
Louis Olsman, Kenosha	x	x
Morris Siegel, Kenosha	o	o

	Sessions 1	Sessions 2
La Crosse		
G. B. Murphy, Jr., La Crosse	x	x
Mark O'Meara, La Crosse	o	o
D. L. Morris, West Salem	x	o
Frederick H. Wolf, La Crosse	o	o
Lafayette		
D. F. Ruf, Darlington	o	o
Lyle L. Olson, Darlington	o	o
Langlade		
Dee W. Dailey, Elcho	o	o
T. C. Fox, Antigo	o	o
Lincoln		
R. J. Henderson, Tomahawk	x	o
J. F. Bigalow, Merrill	x	x
Manitowoc		
T. H. Rees, Manitowoc	x	x
W. F. Smejkal, Manitowoc	o	o
Marathon		
A. H. Stahmer, Wausau	o	o
Roy B. Larson, Wausau	x	x
Marinette—Florence		
C. E. Koepp, Marinette	x	x
J. W. Boren, Jr., Marinette	o	o
Milwaukee		
V. L. Baker, Milwaukee	o	o
R. T. Sproule, Milwaukee	x	x
N. G. Bauch, Milwaukee	o	o
W. L. Coffey, Jr., Milwaukee	x	o
E. L. Bernhart, Milwaukee	x	x
L. E. Rotlman, Milwaukee	o	o
D. J. Carlson, Milwaukee	x	x
R. V. Pittelkow, Milwaukee	o	o
J. F. Cary, Milwaukee	o	o
R. A. Nimz, Milwaukee	o	o
G. E. Collentine, Jr., Milwaukee	x	x
John Bareta, Milwaukee	o	o
E. G. Collins, West Allis	x	x
F. J. Millen, Milwaukee	o	o
W. J. Conen, Milwaukee	x	x
E. J. Schmidt, Wauwatosa	o	o
F. E. Drew, Milwaukee	o	o
P. G. LaBissoniere, Milwaukee	o	o
G. W. Dean, Milwaukee	x	x
Marvin Glicklich, Milwaukee	x	x
Norbert Enzer, Milwaukee	o	o
R. H. Lillie, Milwaukee	o	o
G. W. Hilliard, Milwaukee	x	o
T. F. Jennings, Milwaukee	o	o
G. S. Kilkenny, Milwaukee	x	x
R. J. Snartemo, Milwaukee	o	o
H. M. Klopf, Menomonee Falls	o	o
W. E. Finlayson, Milwaukee	x	o
H. J. Lee, Milwaukee	o	o
W. H. Frackelton, Milwaukee	o	o
George Murphy, South Milwaukee	o	o
R. H. Frederick, West Allis	o	o
Roger Laubenheimer, Milwaukee	o	o
G. F. Flynn, Milwaukee	x	x
Anne Roethke, Milwaukee	x	x
R. R. Watson, Milwaukee	o	o
F. A. Ross, Milwaukee	o	x
T. J. Cox, Milwaukee	o	o
D. M. Ruch, Milwaukee	o	o
K. A. Liefert, Wauwatosa	x	x
A. J. Sanfelippo, Milwaukee	x	x
J. R. O'Connell, Wauwatosa	o	o
K. E. Sauter, Milwaukee	x	o
W. C. Webb, Milwaukee	o	o
H. F. Twelmeyer, Wauwatosa	x	x
D. W. Calvy, Milwaukee	o	o
L. R. Weinshel, Milwaukee	o	o
J. K. Olinger, Wauwatosa	o	o
E. D. Wilkinson, West Allis	x	x
Rex Ruppa, Milwaukee	o	o
S. E. Zawodney, Milwaukee	o	o
J. R. Evrard, Milwaukee	o	o
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R. G. Konicek, Tomah	o	o
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G. R. Sandgren, Suring	o	o
J. R. Culver, Oconto Falls	o	o

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Marvin Wright, Rhinelander	o	o
Henry S. Ashe, Minocqua	o	o
Outagamie		
G. A. Behnke, Kaukauna	o	o
William R. Richards, Appleton	o	o
W. H. Hale, Appleton	o	o
J. G. Bergwall, Hortonville	x	x
Ozaukee		
J. F. Walsh, Port Washington	o	o
R. H. Dorr, Belgium	x	x
Pierce—St. Croix		
C. A. Olson, Baldwin	x	x
F. O. Grassl, River Falls	x	o
Polk		
L. O. Simenstad, Osceola	o	o
R. M. Moore, Frederic	o	o
Portage		
F. E. Gehin, Stevens Point	x	x
A. J. Sowka, Stevens Point	o	o
Price—Taylor		
W. W. Meyer, Medford	x	x
J. L. Murphy, Park Falls	o	o
Racine		
V. J. Burch, Racine	x	o
Wm. J. Little, Jr., Racine	o	o
Warren H. Williamson, Racine	x	o
Marvin W. Nelson, Racine	o	o
Wm. Henken, Racine	x	o
S. M. Cushman, Jr., Racine	o	o
Richland		
R. W. Edwards, Richland Center	o	o
L. M. Pippin, Richland Center	o	x
Rock		
M. F. Purdy, Janesville	x	x
C. M. Carney, Beloit	o	o
D. M. Clark, Beloit	o	o
J. R. Schroder, Janesville	o	o
Rusk		
Joseph E. Murphy, Ladysmith	o	o
Ralph Bennett, Ladysmith	o	o
Sauk		
E. V. Stadel, Reedsburg	o	o
J. A. Tibbits, Reedsburg	x	o
Shawano		
H. F. Laufenburg, Shawano	o	o
Patricia J. Stuff, Bonduel	o	o
Sheboygan		
J. W. McRoberts, Sheboygan	o	o
James S. Jensen, Cedar Grove	x	o
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W. E. Wright, Mondovi	x	x
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Thomas Boston, Hillsboro	o	o
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W. A. Nielsen, West Bend	o	o
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Vincent G. Springer, Neenah	o	o
S. J. Graiewski, Oshkosh	o	o
E. N. Wright, Oshkosh	o	o
H. J. Colgan, Neenah	x	x
Wood		
Russell F. Lewis, Marshfield	x	x
Nelson A. Moffat, Marshfield	o	o
E. C. Glenn, Port Edwards	o	o
John E. Thompson, Nekoosa	o	o
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David Noll, Madison	x	x
Dermatology		
Joel Taxman, Milwaukee	x	x
G. O. Stubenrauch, Milwaukee	o	o
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R. R. Richards, Eau Claire	x	x
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John Wishart, Eau Claire	o	o
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William Wendt, Elm Grove	o	o
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John Doolittle, Madison	o	x
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Marvin Nelson, Racine	o	o
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J. L. Teresi, Brookfield	o	o
L. W. Kleppe, Beloit	x	x
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J. R. Guy, Waukesha	o	o
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C. K. Kincaid, Madison	o	o
G. M. Shinners, Green Bay	x	x
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Howard Mauthe, Fond du Lac	x	x
L. E. Jones, Fond du Lac	o	o
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J. A. Killins, Green Bay	x	o
A. G. Martin, Milwaukee	o	o
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F. M. Hilpert, Racine	x	o
A. J. Jacobsen, Racine	o	o

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Following is a proposed schedule for one week of the course. Adjustments may be made to suit the interests of the registrant. The "visit" which appears frequently in the schedule would be with a member of the faculty as seems indicated by the initial visit with Doctors Lobeck and/or Meyer to outline areas of special interest of the registrant.

SCHEDULE

MONDAY

8:00 a.m.	Visit: Charles C. Lobeck, M.D., Chairman Thomas C. Meyer, M.D.
9:00 a.m.	Cardiac Clinic (1922 University Avenue)
1:00 p.m.	Mental Retardation or Urology (1922 University Avenue)
4:00 p.m.	Visit

TUESDAY

8:00 a.m.	Rounds with Renal/Metabolic Team
11:00 a.m.	Problem Conference
1:00 p.m.	Hematology Clinic (1922 University Avenue)

WEDNESDAY

8:00 a.m.	Rounds with Endocrinology
11:00 a.m.	Visit
1:00 p.m.	Cystic Fibrosis and Renal Clinic (1922 University Avenue)

THURSDAY

8:00 a.m.	Visit
9:00 a.m.	Rounds with Neurology
11:00 a.m.	Grand Rounds
1:00 p.m.	Neurology Clinic (1922 University Avenue)

FRIDAY

8:00 a.m.	Rounds with Hematology
11:00 a.m.	Visit
1:00 p.m.	Endocrinology Clinic (1922 University Avenue)

SATURDAY

8:00 a.m.	Endocrinology/Genetics Rounds

Physicians interested in registering or obtaining more information may contact: Thomas C. Meyer, M.D., Director of Postgraduate Medical Education, Room 413—Extension Building, 432 North Lake Street, Madison (Telephone—Area Code 608–262–8299)

SCHEDULE OF CONFERENCES

The following conferences, presented through the University of Wisconsin Extension Division, will be offered during the coming months at the Wisconsin Center in Madison:

Feb. 8–9—Modern Applications of Column Chromatography

Mar. 31-Apr. 2—Viruses and Clinical Pediatrics

Apr. 7—Prevention and Management of Athletic Injuries

May 4–6—Radiology and Pathology of the Genito-Urinary System

June 2–4—Comprehensive Mental Health: The Challenge of Evaluation

June 15–17—Radio-Therapy (Title to be announced)

Aug. 25–27—Cancer (Title to be announced)

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BRAND REAGENT STRIPS

...broadest urine screening possible from a single reagent strip

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

pH—values are read numerically in the essential range of pH 5 to pH 9.

Protein—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

Glucose—provides a "Yes-or-No" answer for urine "sugar spill."

Ketones—detects ketone bodies in urine—**both** acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

Occult Blood—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).

Ames Company, Inc., Elkhart, Indiana

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The Somatic Mask: chest pain—heart disease or psychic tension?

Precordial pain as well as tachycardia, palpitation, breathlessness and faintness or arrhythmias are classic signs of cardiac disease. In many cases, however, they may represent a "somatic mask"—a psychophysiological equivalent of psychic tension.

Valium (diazepam) reduces the patient's disturbing psychic tension and helps improve such related symptoms as sadness and feelings of hopelessness, fatigue, insomnia, crying spells and nervousness.

In prescribing: Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50.

Valium® (diazepam)

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

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